Strengthening the Nursing and Midwifery Contribution to Health and Healthcare in Ireland – A Strategy for Professional Development in a Changing Health Service

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Volume 1

Declaration

This thesis is presented in fulfilment of the requirements of the PhD Degree of the University of Dublin. It has not hitherto been submitted to any other university. I confirm that this work is entirely my own, except where otherwise acknowledged.

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Yvonne O'Shea

Summary

Over the past 10 years, nursing and midwifery in Ireland has experienced considerable change. This has been driven principally by the implementation of the recommendations of the Commission on Nursing (Government of Ireland, 1998) and the implementation of what has become known as the *Health Service Reform Programme* (DoHC, 2003a). Over the same period Irish society has become wealthier and more culturally diverse. This has brought with it a series of socio-economic and cultural challenges that impact on the health services and on the professions of nursing and midwifery. In 2006, the HSE introduced the Transformation *Programme 2007-2010* (HSE, 2006b), heralding further radical changes for the way in which health services are delivered in Ireland. This has major implications for nursing and midwifery.

The research set out with two aims: first, to identify the role for nursing and midwifery within the Irish Health Services of the future, and second, to identify the professional development implications of this role. Thirteen objectives were identified to achieve these two aims. The objectives focused on defining the future shape of the Irish health services, describing the role nursing and midwifery would be expected to play in these services, identifying the skills nurses and midwives would require to fulfil that role and defining the implications for the education of nurses and midwives. The data gathered in the research was intended to serve as the basis for the formulation of a strategy for the professional development of nursing and midwifery.

The overall research strategy chosen for this study was the case study approach (Stake, 2003). This research is not intended as a contribution to theory, in the same way as a grounded theory approach might be (Locke, 2001; Duffy et al, 2004). It is an intrinsic study of a particular case (Stake, 2003).The research was conducted using qualitative research tools. These included semi-structured interviews and focus groups. A total of 77 semi-structured interviews were conducted. The targets for these interviews were senior figures in the health services such as policy makers, service managers, medical consultants, educators, leaders of nursing and midwifery. A total of 8 focus groups were conducted with groups of senior nurse managers and educators. The results of the research were analysed with the assistance of Ethnograph v5.08, a software tool used for qualitative data analysis. The results were presented and discussed under three headings: the future of health services in Ireland; the changing role of nursing and midwifery in Ireland; building skills and competencies in nursing and midwifery.

The research found that the socio-economic context for the Irish health services of the future will be characterised by increased wealth, greater cultural and ethnic diversity and a more informed, better educated client / patient with greater expectations regarding quality and choice. Service delivery will shift to the community and technology and changes in practice will drive the creation of a primary / acute care continuum. There will be a greater emphasis on accountability in terms of value for money in the use of resources and in terms of personal and professional accountability for those who work within the services.

The research also found that the role of nurses and midwives will develop in line with an enriched career pathway in clinical, management, education and research settings, with a great deal of integration between the pathways. The career pathway will include roles at generalist, specialist and advanced practice. Increasingly, nurses and midwives will be expected to act as autonomous professionals capable of developing nurse-led services in primary and acute care settings and of working as members or leaders of interdisciplinary teams in line with the needs of the services. Nurses and midwives will increasingly have a higher profile in the community and will deliver services to clients / patients close to their own homes. This will require the emergence of leaders of the professions, capable of promoting proactive adaptation to change.

The research also found that the nurses and midwives of the future will require a broad range of skills and competencies that equip them to fulfil their role. This will be built on a solid knowledge base in their own professional area of competence and on a deep understanding of the essence of nursing. This will be underpinned by educational provisions at pre and post-registration levels that have been developed in partnership with the services and that reflect the needs of the professions. There will be a requirement for a rich provision of continuing professional development opportunities which will increasingly be delivered on an interprofessional basis.

Based on the results of the research, a strategy for the professional development of nursing and midwifery was developed. With reference to the results of the research, the strategy examined the strengths, weaknesses, opportunities and threats facing the professions. A statement of vision was drafted, reflecting what nursing and midwifery is likely to look and feel like in the health services of the future. A mission statement, based on the core elements of the essence of nursing, outlined the central role and purpose of nursing and midwifery in line with the needs of the service. The strategy also outlined what the long term objectives of the professions should be in order to meet the expectations of the major stakeholders and a number of key strategies were identified aimed at achieving these objectives. These key strategies aimed to take advantage of the strengths, tackle the weaknesses, exploit the opportunities and avoid the threats that had been identified. They included: (1) Provide strategic coordination and leadership for the professions of nursing and midwifery; (2) Contribute to the integration of the healthcare services in cooperation with other healthcare professionals and support workers; (3) Devise and implement national, regional and local skill mix development plans; (4) Develop nursing and midwifery services; and (5) Build nursing and midwifery capacity in the community. The strategy concluded with an analysis of the strategic action programmes and measures of success that would need to be implemented, while at the same time identifying the key stakeholders that would be involved in the implementation process. The thesis concludes with a summary of the key next steps required, including the need to debate and adapt the strategy at national level and set time based review points.

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Contents

List of Abbreviations

ABA	An Bord Altranais
ADON	Assistant Director of Nursing
A&E	Accident and Emergency
AIDS	Acquired Immune Deficiency Syndrome
AINM	Association of Irish Nurse Managers
AMNCH	Adelaide, Meath and National Children's Hospital
AMP	Advanced Midwife Practitioner
ANP	Advanced Nurse Practitioner
BNS	Bachelor of Nursing Studies
CDPS	Career Development and Planning System
CEO	Chief Executive Officer
CIT	Community Intervention Team
CME	Centre of Midwife Education
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Teams
CMM	Clinical Midwife Manager
CMS	Clinical Midwife Specialist
CNE	Centre of Nurse Education
CNM	Clinical Nurse Manager
CNO	Chief Nursing Officer
CNS	Clinical Nurse Specialist
CPD	Continuing Professional Development
CSO	Central Statistics Office
DATHs	Dublin Academic Teaching Hospitals
DHSS	Department of Health and Social Services
DHSSPS	Department of Health, Social Services and Public Safety
DoH	Department of Health
DoHC	Department of Health and Children
DOMINO	Domiciliary Care In and Out of Hospital

EAG	Expert Advisory Group
EEC	European Economic Community
ERG	External Reference Group
ESRI	Economic and Social Research Institute
EU	European Union
EWTD	European Working Time Directive
FETAC	Further Education and Training Awards Council
FIGO	International Federation of Gynaecology and Obstetrics
GDP	Gross Domestic Product
GFCF	Gross Fixed Capital Formation
GNI	Gross National Income
GP	General Practitioner
HeBE	Health Boards Executive
HICC	Hickman Catheter
HIQA	Health Information and Quality Authority
HITH	Hospitals in the Home
HIV	Human Immunodeficiency Virus
HR	Human Resources
HRB	Health Research Board
HSE	Health Service Executive
HSRP	Health Service Reform Programme
IADNAM	Irish Association of Directors of Nursing and Midwifery
ICM	International Confederation of Midwives
ICT	Information and Communications Technology
ICU	Intensive Care Unit
iHIQA	Interim Health Information and Quality Authority
LEO	Leading an Empowered Organisation
LHO	Local Health Office
MATHS	Major Academic Teaching Hospitals
MWHB	Mid-Western Health Board
NCHDs	Non-Consultant Hospital Doctors
NCVA	National Council for Vocational Awards

National Council	National Council for the Professional Development of Nursing and Midwifery
NDU	Nursing Development Unit
NEHB	North-Eastern Health Board
NHO	National Hospitals Office
NHS	National Health Service
NIDD	National Intellectual Disability Database
NIPEC	Northern Ireland Practice and Education Council
NMPDU	Nursing and Midwifery Planning and Development Unit
NQAI	National Qualifications Authority of Ireland
NSF	National Service Framework
NSSC	National Shared Services Centre
NTPF	National Treatment Purchase Fund
NUI Maynooth	National University of Ireland, Maynooth
OECD	Organisation of Economic Co-operation and Development
OHM	Office for Health Management
PCCC	Primary, Community and Continuing Care Directorate
PCT	Primary Care Team
PEG	Percutaneous Endoscopic Gastronomy
PHN	Public Health Nurse
PICC	Peripheral Inserted Central Catheter
PRERG	Post-Registration Nursing and Midwifery Review Group
RCN	Registered Children's Nurse
RM	Registered Midwife
RMHN	Registered Mental Handicapped Nurse
RNID	Registered Nurse Intellectual Disability
RNMH	Registered Nurse of the Mentally Handicapped
RNP	Registered Nurse Prescriber
RPN	Registered Psychiatric Nurse
RSCN	Registered Sick Children's Nurse

SHA	Southern Health Area
SKILL	Securing Knowledge Intra Lifelong Learning
SLMRU	Skills and Labour Market Research Unit
SWTRHA	South West Thames Regional Health Authority
TIGER	Technology Informatics Guiding Education Reform
UCD	University College Dublin
WHO	World Health Organisation

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Introduction – Rationale and Scope of the Research and Outline of Structure of Thesis

The purpose of this introduction is to:

1. Explain the underlying rationale for the research that is presented in this thesis.

2. Define the range and extent of the research, including a definition of its inherent limitations.

3. Provide an introduction to the structure of the thesis, including an outline of each of the chapters that follow.

1.1 Rationale for this Research

The research sets out with two aims: first, to identify the role for nursing and midwifery within the Irish health services of the future, and, second, to identify the professional development implications of this role.

A number of research questions emerged naturally from these aims. These questions were:

- What policies exist about the future of the health services and what do they say?
- Based on this policy context, what is the likely shape of the health services of the future?
- What is the intention of the policy with regard to the role of nurses and midwives in the health services of the future?
- In what way does this future role differ from the current role?
- Is the future role of nurses and midwives understood by the key players involved in the health services?
- What are the implications of this role for relationships between professionals and between institutional settings?

- What are the skills and competencies that will be required to fulfil this future role?
- Do these skills and competencies differ from those that are required now?
- Do nurses and midwives currently possess the necessary skills and competencies to fulfil their future role?
- Are nurses and midwives adequately prepared for the change in role that is envisaged for them?
- How suitable is the current provision of professional development opportunities for nurses and midwives to prepare them for their future role?
- What changes are required to the provision of professional development opportunities for nurses and midwives to prepare them for this role?
- Is it possible to formulate a strategy for the professional development of nursing and midwifery that will help to prepare nurses and midwives for their future role?

It is intended that the aims of this research and the research questions that emerge from them will assist in the production of a **strategy for the professional development of nursing and midwifery in a changing health service**. This is the principle rationale for this research and the main output that is sought.

The rationale for this research was provided by the major changes that are taking place within the health services as a result of the Health Service Reform Programme (DoHC, 2003a). The Irish health services have been transformed in recent years and it is clear, from the dynamic nature of the changes that are taking place, that the change process is not complete. We are living in an evolving, constantly changing health service. The future is going to be quite different.

Nursing and midwifery has also been transformed in recent years, due principally to the implementation of the recommendations of the Commission on Nursing (Government of Ireland, 1998). These changes have equipped nursing and midwifery to play an increasingly important role in the planning and

delivery of health services. It is clear from the way in which the health services are evolving that much is expected from nursing and midwifery in the future. It is timely therefore to take time to reflect on what these expectations are and what implications this has for the development of the profession.

The idea of conducting a comprehensive, in-depth analysis of the questions raised by the aims of the research and producing a strategy for the professional development of the professions is at the heart of this thesis. In order to do this, it emerged early on in the analysis that it would be necessary to conduct extensive face to face primary research with the key stakeholders within the Irish health services, as will be demonstrated later in this thesis when the selection of methodology is discussed (chapter 4).

The author of this research is the Chief Executive of the National Council for the Professional Development of Nursing and Midwifery (National Council), which was established on foot of a recommendation of the Commission on Nursing (Government of Ireland, 1998) with responsibility for the professional development of the role of nursing and midwifery in line with the needs of the service and of patients and clients, and with specific responsibility for the development of clinical career pathways for nursing and midwifery. The theme of this research is therefore intimately associated with the work of the National Council. This work involves a great deal of contact with large numbers of nurses and midwives. This has been an important stimulus for conducting this research.

1.2 Scope of this Research

The scope and extent of the research is defined by the nature of the research questions.

In the first instance, it is clear from the research questions that the focus of the research is on policy and strategy. It is not the intention of this research to contribute to the development of theories but rather to the formulation of policies and strategies related to professional development. This is a very important

consideration that needs to be emphasised at the outset of this thesis. It is not the intention of this thesis to conduct a sociological or phenomenological study of nursing within the health services in Ireland.

For that reason, in defining what is meant by the use of the term 'role', it is not intended to introduce a discourse on role theory. A pragmatic rather than a theoretical approach has been adopted to addressing the question of role. In practice, nursing and midwifery adapt to the changing needs of the health services by expanding and developing their role. In Ireland this is bounded by the Scope of Nursing and Midwifery Practice Framework (An Bord Altranais, 2000a) that provides a guide to the way in which this expansion of practice should take place. It has grown into the development of a number of career pathways for nurses and midwives, from the generalist to the specialist and the advanced practice in the clinical area, and into other areas of education, policy and management. Role development for nurses and midwives is at the heart of the policy agenda in the Irish health services. This is what is understood by role in this research. Role theory on the other hand, is related to a sociological approach to conducting a study. It examines the characteristics of expected behaviour patterns for a particular group within society. This research focuses more on the policy context within which nursing and midwifery operate as professions, and how this role is defined by changing circumstances within that environment – this is a more pragmatic approach rather than a theoretical approach.

A similarly pragmatic approach is adopted in defining what is meant by professional development within this research. The research is based on a distinction between on the one hand the professional development of the individual nurse and midwife, and on the other, the development of the professions of nursing and midwifery in a policy context.

The development of the individual professional is understood as a lifelong process, which includes both structured and informal activities that may include formal education programmes, participation in journal clubs, case conferencing, clinical supervision, learning sets, preceptorship, mentorship, workshops,

distance learning programmes and reflection on practice (National Council, 2003a). This is what is understood by continuous professional development (CPD) and it encompasses processes, activities and experiences that contribute towards the development of a nurse or midwife, both personally and professionally (National Council, 2003a). It is a lifelong process of learning which stimulates and empowers individuals to acquire all the knowledge, values, skills and understanding they will require throughout their lifetimes and to apply them with competence, creativity and enjoyment in all roles, circumstances and environments (Medel Anonuevo, 2001).

The development of the profession of nursing and midwifery refers to the development of the profession as a whole within the policy environment for Irish health services. This is encompassed in the last research question that was identified, i.e. the formulation of a strategy for the future professional development of nursing and midwifery. Strategy formulation is therefore an integral part of the objectives of this research. This begs the question – what is meant by 'strategy'?

A strategy is a long term plan of action designed to achieve a particular goal. The goal in this case is to develop the profession of nursing and midwifery in a manner that ensures that nurses and midwives can fulfil their role in the health services of the future.

This emphasis in the research on policy and strategy rather than theory has a number of important implications.

One of the implications of the emphasis on policy rather than on theory is that the literature review that will be conducted as part of the research will concentrate on policy and policy related literature. The main purpose of the literature review in this case is to analyse in detail the policy context for nursing and midwifery within the Irish healthcare services. This review of the literature on policy in Ireland will help to identify the key questions that are being addressed in the reform of the health services and how these impact on nursing and midwifery. This analysis is an essential pre condition for the preparation

and implementation of the primary research on which most of this thesis is based. In this sense, the literature review is focused entirely on the research aims and the research questions that form the basis for this thesis.

Another important implication to emerge from the definition of the scope of the research is the importance of the primary research. Because of this emphasis on policy and strategy rather than on theory, the primary research assumes a high level of importance. The definition of the targets for the primary research (policy makers, service managers, medical consultants, educators, directors of the nursing and midwifery planning and development units (NMPDUs), directors of nursing and midwifery (hospital and community)) provides the material for the determination of the most appropriate strategic response from nursing and midwifery to the policy environment within which future health services in Ireland will be delivered.

1.3 Chapter Outline

Chapter 1 provides a detailed review of the context in which Irish nursing and midwifery operates. The chapter begins with a review of some of the key social, demographic and epidemiological trends that prevail in Ireland today. This includes some analysis of trends in population growth, labour force, health services data, mortality and lifestyle. Together, these facts provide a picture of the broad socio-economic backdrop against which nursing and midwifery services in Ireland are developing. The second part of this chapter consists of a detailed review of the key policy developments that have taken place in the health services in Ireland. The emphasis in this review is on those policy instruments that have driven the reform of the Irish health services in recent years. Comparisons are drawn in this review with similar developments in the United Kingdom and with previous policy initiatives in Ireland. The review also includes a descriptive analysis of other policy initiatives within the health services that are of relevance to nursing and midwifery. Chapter 1 concludes with a summary of the issues that arise from the review of context. These issues

provide material that informs the discussion of the results of the primary research that is presented in subsequent chapters (chapters 5, 6, 7 & 8).

Chapter 2 provides a detailed review of the development of nursing and midwifery in Ireland. This includes an account of the emergence of nursing and midwifery as a regulated profession subject to statutory registration procedures and the development of the branches of the register. It also includes an analysis of the way in which the role of nursing and midwifery has developed through policy initiatives such as the Commission on Nursing and the work of the National Council for the Professional Development of Nursing and Midwifery (National Council) and the emergence of a clear clinical career pathway for nurses and midwives in Ireland. The review also looks at recent developments in the role that have occurred as a response to policy changes in the health services such as the emergence of a range of nurse and midwife led services, the introduction of nurse and midwifery prescribing and the way in which the management of nursing and midwifery has evolved. An important element in the development of the role of nursing and midwifery is the provision of education and professional development for nurses and midwives. The review looks at the way in which these have been reformed and developed over recent years and the developments envisaged for the future. The emergence of joint appointments between clinical and educational settings is also reviewed as an important dimension in the development of the role of nurses and midwives within the health services. The many developments in the role of nursing and midwifery in Ireland that have taking place in recent years, and in particular the increased emphasis on the importance of specialisation and advanced practice, beg the question what is the essence of nursing? This chapter provides some reflections on this question with a view to providing a touchstone for the remainder of this thesis on what is understood by nursing and midwifery and what the core elements of the profession are.

Chapter 3 provides an in-depth analysis of some of the key considerations that need to be borne in mind when preparing a strategy for the professional development of nursing and midwifery. Recruitment and retention of nurses and midwives is a theme that has been and is likely to continue to be a

significant challenge to policy makers and service managers. Policy initiatives in this area in Ireland are reviewed in this chapter as well as initiatives from abroad that can provide important lessons for the future. In addition, there have been important policy and service management interventions in recent years in nursing and midwifery in Ireland in the areas of leadership and empowerment for nurses and midwives. As we face a future in which the shape of the health services in Ireland are undergoing radical change, leadership and empowerment within the professions will assume great strategic importance. For that reason, the review provides an analysis of these interventions and a critical appraisal of the issues that they raise. Strategic planning for professional development is not something that is unique to Ireland. There are examples of good practice in a number of countries that contain lessons that will be of value in seeking to prepare a strategy that meets the challenges of the future health services. For that reason, the chapter examines some international examples of strategic planning for the professions (the World Health Organisation, The United Kingdom and Canada). Finally, the chapter concludes with a summary of the issues that have emerged from this review that inform the discussion of the results of the primary research that is presented in subsequent chapters (chapters 5, 6, 7 and 8).

In chapter 4, a detailed account of the methodology that was used in the primary research is provided. This includes a definition of the aims and objectives of the research and the theoretical framework that underpins the selection of the methodological strategy. The chapter also provides details of the data to be gathered, the population, samples and data collection methods chosen, and an analysis of issues surrounding questions of gaining access and scheduling. In addition, the research instruments to be used and the data analysis techniques are described and discussed. Ethical considerations are an important element of every primary research. The chapter provides a detailed discussion of the ethical issues involved in this research. The practical implementation of the methodology is also reflected on in this chapter, with particular emphasis on the questions of validity and reliability of the data gathered. Finally, the chapter concludes with an introduction to the data analysis and discussion chapters that follow.

The next three chapters (5, 6 & 7) present and critically discuss the results of the primary research. In chapter 5, the future shape of the health services in Ireland is discussed, using headings that emerged from the analysis of the primary data. Chapter 6 does the same for the changing role of nursing and midwifery, while chapter 7 looks at building skills and competencies in nursing and midwifery to meet the challenges of the future. Each of these chapters provide a number of conclusions that emerge from the primary research with reference also to the issues raised in chapters 2 and 3. The discussion in chapters 5, 6 & 7 is peppered with references to the review carried out in chapters 1, 2 and 3 and introduces also where relevant, additional topical references to illustrate points that are being raised.

Chapter 8 represents the culmination of the work of this thesis by addressing the last of the research questions identified, i.e. the formulation of a strategy for the professional development of nursing and midwifery in a changing health service.

Chapter 1 – The Context for Nursing and Midwifery in Ireland

1.1 Introduction

Nursing and midwifery in Ireland operate within a context that includes social, economic, demographic and epidemiological factors. It also includes policy responses to the needs of the population and the growing demands of the health services. In this chapter, a description of this context is provided. It helps to set the scene for the whole thesis and will enable us to draw some conclusions about the context within which nursing and midwifery operate and the impact this is likely to have on the development of a strategy for the future of the professions. The chapter also provides important contextual material of relevance to the primary research that is to follow. The primary research contained in this thesis consists of interviews with key stakeholders within the health services. Their comments and observations are made against the backdrop of the kind of factors that are discussed in this chapter. It is important for that reason that these are articulated at this stage.

1.2 Socio-Economic Factors

1.2.1 Population and Economic Change

The impact of the so-called Celtic Tiger economic boom of the past decade is frequently reported as having transformed Ireland, and sometimes the reports are of negative social consequences. A recent report entitled *Best of Times? The Social Impact of the Celtic Tiger*, (Fahey et al, 2007), which brings together the work of social researchers from the ESRI, NUI Maynooth and UCD, concluded that the social impact of progress has been largely positive, resulting in a decline in poverty rates, increased social mobility and improvements in the health of the nation.

In 2007, the Central Statistics Office published the third report in the series *Measuring Ireland's Progress 2006* (Government of Ireland, 2007a). The report provides a detailed analysis of Ireland's situation in respect of key economic, social and statistical indicators in comparison with other EU countries. The picture that emerges from the report is of a country that has experienced extraordinary growth in population and in the economy in recent years. The following list of facts and statistics (based on Government of Ireland, 2007a and other reports) paint a picture of a country that has experienced and is likely to continue to experience significant change.

1. In 2005, Ireland had the second highest Gross Domestic Product (GDP) per capita, expressed in terms of purchasing power standards within the EU at 38.9% above the EU average. Based on Gross National Income (GNI), Ireland was in fifth place at 18.6% above the EU 25 average. Investment in Ireland in Gross Fixed Capital Formation (GFCF) increased by almost 43% over the period 1996-2005. In each year since 1997, Ireland has invested a higher proportion of GDP in GFCF than the EU 25 average (Government of Ireland, 2007a).

2. An average of €2,223 (at constant 2003 prices) per person was spent on non-capital public expenditure on health care in Ireland in 2004. This represented an increase of over 80% on the 1995 level.

3. Non-capital public expenditure on education per student rose by 45.2% between 1996 and 2005, after allowing for inflation. Most of the increased expenditure was directed towards primary and secondary education.

4. The population in Ireland increased by 15.7% to almost 4.24 million persons in the period 1997-2006. This was the second highest rate of increase in the EU 27 behind Cyprus. The fertility rate in Ireland was the second highest in the EU after France in 2005, at a rate of 1.88 compared to an EU 25 average of 1.52. Life expectancy at birth was 81.8 years for Irish women and 77.1 years for Irish men in 2005. Life expectancy for men

in Ireland was 1.3 years above the EU 25 average of 75.8 years, while that for women was 0.1 years below the EU 25 average of 81.9 years.

5. According to the *Population and Labour Force Projections 2006-2036* (CSO, 2004) the older population (i.e. those aged 65 years and over) is projected to increase very significantly from its 2001 level of 430,000 to over 1.1 million by 2036. The very old population (i.e. those aged 80 years of age and over) is set to rise even more dramatically from the 2001 level of 98,000 to a projected 323,000 in 2036. The average annual number of deaths will increase steadily from a current figure of fewer than 30,000 to over 40,000 in the period 2031-2036. The natural increase in the population (i.e., the excess of births over deaths) is projected to decline; however, it will remain positive over the course of the projection period (2006 to 2036). The young population (827,500) was almost double the old population (430,000) in 2001. However, by 2036 it is projected that there will be more older persons than younger persons (i.e. 1,119,000 persons aged 65 years and over compared with just 750,000 persons aged 0-14 years).

6. Non Irish nationals accounted for one in eight workers in the state and one in three workers in the hotel and restaurant sector in 2006. More than a quarter of the population of large areas of Dublin, including most of the city centre and parts of Blanchardstown, Clondalkin, and Tallaght are immigrants (CSO, 2006). Similar patterns emerge in the city centres of Cork and Limerick. There was a 53% increase in the immigrant population between 2002 and 2006 and foreign born residents accounted for 14% of the population in 2006, compared with 10% in 2002 (CSO, 2006).

7. The employment rate in Ireland rose from 56.1% in 1997 to 68.1% in 2006. The rate for women increased by over 14 percentage points over that period, while the rate for men rose by around 10 percentage points. Productivity in Ireland, measured as GDP per person employed, was the second highest in the EU 27 in 2005. The unemployment rate in Ireland increased from a low point of 3.6% in 2001 to 4.3% in 2006. Ireland had

the third lowest unemployment rate in the EU in 2006 at just over half of the EU 27 average of 7.9%. The long-term unemployment rate in Ireland was 1.4% in 2005, which was lower than the EU 27 average of 4%. The employment rate of persons aged 55-64 at 51.7% was higher than the EU 27 average of 42.3% in 2005. However only 37.4% of women in Ireland in this age group were in employment compared to 65.7% of men (Government of Ireland, 2007a).

8. There has been a 17% increase in the number of people in the labour force in the past four years. Agriculture accounted for less than 5% of total employment in 2006, compared with over 50% in 1926. Female labour force participation increased sharply from 29.7% in 1981 to 52.8% in 2006. The percentage of women describing themselves as home makers, staying at home, fell from 54.9% in 1981 to 21.8% in 2006 (CSO, 2006).

9. There were almost 161,000 unpaid carers in the State in 2006, just under 5% of the population. Women accounted for 62% of carers with most of them in their 40s or 50s (CSO, 2006).

10. Over 6% of men and 7.5% of women in Ireland were in consistent poverty in 2005. Unemployed people were most likely to be in consistent poverty. The proportion of Irish people at risk of poverty, after pensions and social transfer payments were taken into account, was 20% in 2005. This was one of the highest rates in the EU 27. The effect of pensions and social transfers on reducing the at-risk-of-poverty rate was low in Ireland compared with other EU 27 countries. In 2004, social protection expenditure in Ireland was 17% of GDP. This was just over half of the rate in Sweden.

11. The pupil-teacher ratio at primary level in Ireland in the school year 2003/2004 was one of the highest in the EU 27 at 18.3. Twelve of the other twenty-six EU member states had a pupil-teacher ratio of less than 15 at primary level. Early school leavers represented 12.3% of the 18-24

age group in Ireland in 2006. The unemployment rate for early school leavers in this age group was 19% in 2006 compared with an unemployment rate of 8.2% for all persons aged 18-24.

It is clear from these statistics that Ireland has become a wealthy country in a relatively short period of time and is beginning to invest in social services such as education and health at an increased rate compared to what was possible in the past. This would indicate that we are looking at a country that is in transition as it seeks to build up its capital infrastructure in key social services. In addition, it is clear from the statistics that problems of social exclusion and poverty continue to be significant (as illustrated by the levels of poverty and early school leavers).

The significant growth in population and, in particular, the significant increase in the multicultural and multi-ethnic make up of the population and of the workforce presents challenges for service planners and service deliverers. These challenges include the ability to adapt to a more diverse set of cultural contexts. Multi-ethnicity and multi-culturalism present significant communications challenges within the health services. The danger of introducing barriers within health service delivery is also a natural corollary of multi-cultural service deliverers and clients.

While Ireland has a relatively young population at present compared to other EU countries, the future prospects are for a significant increase in the number of older people. The ageing of the population over the next 20 to 30 years will present a number of important social and policy challenges. It will change the level of dependency that exists within the country and will require the development of services to cater for the needs of an increased number of older people.

Increased participation by women in the labour force and has significant implications for the way in which we shape the primary care provisions of the future, the aspirations of which are frequently based on a traditional view of what the family framework is likely to be. The implications of these

considerations are that there is a need to look again at the support that is given to families and carers in their own homes, and taking account of the changing nature of 'family frameworks'.

1.2.2 Health Services Data

Like the economy and the rest of Irish society, Irish health services are currently undergoing a period of change and could be described as being in transition. Some of the key features of the health services can be described in the following facts and statistics (based on a number of sources):

1. The number of people employed in the health services in Ireland in December 2006 was 106,273; of these 36,737 were nurses (35%); 7,712 were Medical / Dental staff (7%); 14,913 (14%) were health and social care professionals; 16,739 (16%) were other patient and client care staff; the remainder were employed in management and administration (17,262 – 16%) and general support staff (12,910 – 12%) (DoHC, 2007). The following table provides a summary of these figures:

Table 1.1 – Employment in Health Services in Ireland 2006

Nurses	36,737	35%
Medical /Dental	7,712	7%
Health and social care professionals	14,913	14%
Other patient and client care staff	16,739	16%
Management and administration	17,262	16%
General support staff	12,910	12%
Total	106,273	100%

2. In July 2007, the OECD published statistics on health care in member countries (OECD, 2007). The report contains some key facts on resource levels within the health services in Ireland. Despite increasing numbers of doctors in recent years, Ireland continues to have a lower number of physicians per capita than in many other OECD countries. In 2005, Ireland had 2.8 physicians per 1,000 population, compared with an OECD

average of 3.0. While the number of doctors per capita in Ireland is higher than in the United States, Canada, the United Kingdom and Australia, it is lower than in a number of European countries such as France, Germany and Sweden (which all record 3.4 physicians per 1,000 population. On the other hand, Ireland has a very high number of practising nurses, with 15.2 nurses per 1,000 population in 2005, compared with an OECD average of 8.6. It is important to note however that the comparability of data on nurses is more limited, due to the inclusion of different classes of nurses and midwives in the data reported by different countries.

3. *The Report of the Economic and* Social *Research Institute* (ESRI, 2002) shows that there had been a very significant increase in the levels of activity in Irish acute public hospitals for the period 1990-1999. Numbers of people treated in 1999 had increased by over 40% on the figures for 1990, to 800,000. Much of this was attributed to reductions in the length of patient/client stays and the increase in the number of day beds in hospitals, which resulted in increased use of day services. In 1990 one in ten people discharged from acute hospitals had been treated on a day basis. By 1999 this had increased to one in 3.

4. The number of beds in extended care facilities in Ireland in 2003 was 23,825. The bed occupancy rate was 88.9%, with a total of 21,169 patients. Of these, 11,486 beds were in private nursing homes, with a bed occupancy rate of 86.8% and total number of patients 9,965 (ESRI, 2003). The number of acute care hospital beds in Ireland in 2005 was 2.8 per 1,000 population, below the OECD average of 3.9 beds per 1,000 population. In most OECD countries including Ireland, the number of hospital beds per capita has fallen over time.

5. The number of in-patients in all psychiatric hospitals and units in Ireland at 31 December 2001 and 2002 was 4256 and 3891 respectively (Health Research Board, 2002). The main focus of care in the mental health services is now in the community as the number of in-patients/clients in psychiatric hospitals has been decreasing over recent years, with the focus of in-patient care being only for short term acute episodes or for

chronically disturbed patients/clients who cannot function in lower support environments. According to statistics released by the Department of Health and Children (DoHC) in 2001, it was estimated at that time that one person in four would suffer from mental illness at some stage during their lives, and that 25% of families were likely to have at least one member suffering from a mental illness. In addition, the incidence of depression in Ireland was estimated to be 10% of the population and schizophrenia was 1% (DoHC, 2001a). Suicide has been shown to be strongly related to depression. The number of deaths from suicide has decreased from a high of 478 in 2002 to 409 in 2006 (CSO, 2007).

6. In April 2004 there were 25,416 people registered on the National Intellectual Disability Database (NIDD) of the Health Research Board (HRB), with a prevalence of 6.49 per 1,000 of the total population. The prevalence rate for mild ID is 2.3 per 1,000 and the prevalence rate for moderate, severe and profound ID is 3.73 per 1,000 (HRB, 2004). The number of people with intellectual disability in residential placements in Ireland in 2001 was 8,205. This number reduced to 7,999 in 2002 (HRB, 2004). The number of persons availing of day programmes for people with intellectual disability in 2002 was 22,443. Of these, 7,542 were persons in residential placements, and 14,901 were day attenders (HRB, 2004). The corresponding figures for 2001 were 22,748, 7362 and 15,386.

7. The health status of children in Ireland, and in particular the rate of infant mortality, has seen very significant improvements in recent years. However the rate of improvement has not been as large nor as sustained as is evident in other European countries (DoHC, 1999a; DoHC, 2002a). The immunisation rates for children at 24 months (percentage uptake) in 2002 was between 82% and 83% for diphtheria, haemophilus influenza type B, pertussis, polio and tetanus. The rate for measles, mumps and rubella was 73% (DoHC, 2002a).

8. Most people in Ireland today can expect to live into old age. This is in striking contrast to the situation at the beginning of the century, where life

expectancy was around 50 years. According to data available on the website of the CSO in October 2007 (CSO, 2007), at the end of 2006 the greatest causes of mortality in Ireland were circulatory disease (35%), malignant neoplasms (29%), respiratory diseases (14%), and injuries and poisonings (5%). The overall death rate per 100,000 of population in Ireland has decreased from 1136.8 in 1972 to 749.2 in 2002. Deaths from circulatory diseases over the same period have declined from 579.6 in 1972 to 296.0 in 2002. Deaths from cancer for the same period have increased from 190.5 in 1972 to 191.4 in 2002. However in the case of cancer, the death rate in 1992 had increased to 212.1 and has decreased over the following 10 years to 191.4 in 2002. Deaths from external causes of injury and poisoning have declined over the same period from 55.5 in 1972 to 39.3 in 2002 (WHO, 2004).

9. The *National Health and Lifestyle Surveys* (Friel *et al* 1999) monitor lifestyle and health related indicators. In 1999 the *Survey* reported that 32% of adults were overweight and that exercise was likely to decrease with age. It also reported that most adults consumed alcohol and that one in four exceeded the recommended weekly limits for sensible drinking. Less healthy lifestyles were observed in lower socio-economic groups. The second *National Health and Lifestyle Surveys* (Kelleher et al, 2003) states that there has been a 2% drop since 1998 in the percentage of school-age children smoking, particularly in the 12-14 year age group. In relation to alcohol consumption, the report found that there had been an increase of 9% in the numbers of school age children who had never consumed an alcoholic drink, being most marked in 10-11 year olds. In 2002 the *Survey* reported that rates of obesity had increased by 3%, but the percentage engaging in physical exercise had improved in some age groups. The survey also reported that there was a strong inverse trend according to educational status at all ages, and that there were only modest drops in rates of smoking (Kelleher et al, 2003). In 2005, the Department of Health and Children (DoHC) published an analysis of the problem of obesity in Ireland (DoHC 2005a). The *Report of the National Task Force on Obesity* reported that obesity is now a major public health

problem throughout Europe. In Ireland 39% of adults are overweight and 18% are obese. Of these, slightly more men than women are obese. There is a higher incidence of the disease in the lower socio-economic groups. The report suggests that the problem is particularly acute in relation to childhood obesity and authoritative estimates put the number of overweight and obese children on the island of Ireland at more than 300,000 and that this number is rising at a rate of over 10,000 per year.

It is clear from these statistics that there has been a significant increase in the levels of activity within the Irish health services. This is a direct result of the decrease in the length of stay in acute hospitals. The implications of this is that there is a need for a shift to more community based follow up care. This is particularly evident in psychiatric services where the numbers of in-patient cases has declined significantly over recent years.

An increase in life expectancy means that we will have an increasingly older population. This confirms the projections provided in relation to population growth (1.2.1). The health services will also have to contend with an increase in lifestyle related illnesses and conditions.

It is also clear from these statistics that nurses make up the largest group of health care professionals (35%). This means that the bulk of healthcare delivery will fall on this group of professionals.

1.3 The Health Service Reform Programme

The future of the Irish health services is being driven by what has become known as the Health Service Reform Programme (HSRP). It is based on the recommendations that emerged from a number of reports, including: *Audit of Structures and Functions in the Health Services*, commonly referred to as the *Prospectus Report* (DoHC, 2003b); *Report of the Commission on Financial Management and Control in the Health Service*, commonly referred to as the

Brennan Report (Government of Ireland, 2003); and *Report of the National Taskforce on Medical Staffing*, commonly referred to as the *Hanly Report* (DoHC, 2003c). The reports were commissioned after the publication of the Health Strategy *Quality and Fairness* (DoHC, 2001a) and the key recommendations were:

- A new national management structure for the health service
- A reduction in the number of agencies involved in the planning and delivery of health and personal social services
- New financial accountability systems
- A reconfiguration of hospital services.

A brief outline of the main features of the Health Service Reform Programme (HSRP) is contained in a publication entitled *Health Service Reform Programme* (DoHC, 2003a).

In order to understand the implications for the future of the Irish health services, it is important to consider each of the elements of the HSRP in turn, i.e. the *Health Strategy*, the *Prospectus Report*, the *Brennan Report* and the *Hanly Report*.

1.3.1 Health Strategy

As a result of the Strategic Management Initiative (Government of Ireland, 1994; Department of the Taoiseach, 1996) and in particular the *Public Service Management Act of 1997* (Government of Ireland, 1997a) all Government Departments and Agencies in Ireland are required to produce three or five-year strategy documents. Since the introduction of this requirement, the DoHC has produced a number of strategy documents. The strategy for 2001was entitled *Health Strategy: Quality and Fairness – A Health System For You* (DoHC, 2001a).

It builds on the planned and strategic approach of the previous health strategies and upon the publication and implementation of other health-related strategies. The health strategy outlines a programme of investment and reform of the

health system which was to be implemented over the next decade. It sets clear priorities but also involves all elements of the system. A distinguishing feature of the strategy is the unique level of consultation with individuals, professional groups, disciplines, voluntary organisations and state agencies on which it was based. The guiding principles are equity, people-centredness, quality and accountability.

There are many proposed developments and reforms contained within the strategy document, the implementation of which are shaped by the four overarching national goals of

- Better health for everyone
- Fair access to publicly funded services
- Responsive and appropriate care delivery by an effective and efficient health system, and
- High performance in terms of quality of care, planning and decision-making, and accountability.

Subsidiary to these goals are objectives and actions to help achieve them. The key actions are detailed under six frameworks for change, together with the structural changes and system-wide changes required.

The relevance of the health strategy to nurses and midwives cannot be overstated. They are shown to comprise the largest group of staff in the public health services. Specific nursing roles are mentioned, such as Advanced Nurse Practitioner(ANP), as are opportunities and supports for professional development.

In keeping with the principle of people-centredness, the strategy refers to the need for integrated, continuous, high-quality services and greater interdisciplinary working. An example of this is the requirement for greater coordination between child welfare and protection, and primary care services such as general practice and public health nursing, and child and adolescent

psychiatric teams. This should be a catalyst for nurses and midwives working in primary care settings to develop their knowledge of and skills in working with children with mental health problems by liaising more closely with nurses working in psychiatric or intellectual disability services.

The health strategy describes the health service workforce, of which nurses and midwives make up almost 36%, as highly committed and dedicated and as having enabled very significant developments to be undertaken. It suggests that this same workforce can overcome obstacles to a more integrated or seamless service through the development and implementation of information technology systems, data and information sharing, and the reduction of the professional and structural barriers. Advances in information technology are viewed as likely to revolutionise care. These advances include patient care databases and opportunities to work to standardised evidence-based protocols and decision-support systems.

A national goal of the health strategy is responsive and appropriate care delivery. This goal aims to gear the health system to respond appropriately and adequately to the needs of individuals and families. It is also concerned with ensuring that the various parts of the system are being utilised to their maximum effectiveness and efficiency. Objectives related to this goal include ensuring that the system has the capacity to deliver timely and appropriate services and that the patient is at the centre in the delivery of care. In order to achieve this, the strategy states that an integrated approach to care planning for individuals will become a consistent feature of the system.

A further goal is high performance, which relates to quality of care, planning and decision-making, the efficiency and effectiveness of the system, commitment to continuous improvement and full accountability. The principles of quality and accountability are embraced by the objectives identified under this goal. These objectives are concerned with standardised quality systems to support best patient care and safety, and evidence and strategic objectives to underpin all planning/decision-making. An evidence-based approach to

decision-making requires research findings, qualitative and quantitative data, and other documented trends and behaviours.

The frameworks for the change required in the health system include an information framework aimed at improving performance by supporting quality, planning and evidence-based decision-making in the health system. Good information systems are seen to support equity of access to the health system. The key elements of this framework are:

- Appropriate, comprehensive, high-quality, accessible and timely information on which to plan and organise the health system
- Investment in national health information systems as set out in the *Health Information – A National Strategy* published in 2004 (DoHC, 2004).
- Development of electronic health records to enhance the quality and safety of care.

1.3.2 Reform of Structures

The reform of structures for the delivery of health services in Ireland today has been driven by the *Audit of Structures and Functions in the Health Service* (DoHC, 2003b). This has become known as the *Prospectus Report*, the primary objective of which, was to establish the organisational improvements needed to strengthen the capacity of the health system to meet the challenges of implementing the programme of development and reform set out in the health strategy. Fifty-eight agencies were included in the audit. The key proposals for reform of the health system as enumerated in the *Prospectus Report* concern:

- The creation of a consolidated health care structure
- Strengthening of the functioning of the consolidated structure through the development of supporting processes
- Strengthening of governance and accountability across the system
- Re-organisation of existing agencies and their functions in line with the consolidated structure.

In order to create a health system that is accountable, effective, efficient and capable of responding to the emerging and ongoing needs of the public, the following key reforms have been identified in the HSRP:

- Major rationalisation of existing health service agencies to reduce fragmentation
- Re-organisation of the DoHC, to ensure improved policy development and oversight
- Establishment of a Health Service Executive (HSE) which would be the first ever body charged with managing the health service as a single national entity
- Establishment of three core areas within the HSE: a National Hospitals' Office (NHO), a Primary, Community and Continuing Care Directorate (PCCC) and a National Shared Services Centre
- Establishment of four Regional Health Offices within the HSE to deliver regional and local services
- Immediate establishment of an interim National Hospitals' Office (NHO) with the priority being the reform of the hospital sector
- Establishment of a Health Information and Quality Authority (HIQA) to ensure that quality of care is promoted throughout the system
- Move to devolving responsibility for care budgets to the people actually in charge of delivering that care
- Complete modernisation of supporting processes (service planning, management reporting, etc) to improve planning and delivery of services, including maximising the impact of public funding.

In order to consolidate the system further and reduce the fragmentation that undermines the national management of the system, the report recommended that up to twenty-five existing agencies should be subsumed into the HSE, HIQA or the restructured DoHC. In addition, another seven bodies should be otherwise merged or abolished.

In December 2004 the Tánaiste and Minister for Health and Children, Ms Mary Harney, TD, signed the relevant Orders bringing the HSE into operation with effect from 1 January 2005 (Government of Ireland, 2004). The basis of the HSRP is the separation of policy formulation from service delivery. The DoHC would henceforth concentrate on policy formulation and evaluation and the Minister would hold the HSE to account for the delivery, within budget, of publicly funded health services. The HSE would, in turn, manage the health service as a single national entity and it will also provide advice to the Minister and contribute to policy formulation.

The organisational structure of the HSE has developed since it was first introduced. Appendix 1 presents the structure as it existed in October 2007. The organisation is divided into four divisions: Health and Personal Social Services, Support Structures, the Office of the Chief Executive Officer (CEO) and Reform and Innovation. The principal service delivery arm of the HSE is the Health and Personal Social Services Division. This consists of three pillars of service including Population Health, Primary, Community and Continuing Care (PCCC), and the National Hospitals Office. Appendix 2 provides a further breakdown of this important division.

The division is divided into what have become known as the three pillars of service delivery. They include –

1. Population Health, which includes functional units for health protection, health promotion, environmental health, emergency planning, strategic planning and evaluation, health intelligence and transition and change.

2. PCCC (Primary, Community and Continuing Care), which includes functional units that cover four geographic areas (Dublin – Mid Leinster, Dublin – North East, South, West), each of which, in addition to the management of services within their own geographic area, has national responsibility for a different area of care (i.e. (1) primary care; (2) children, youth, family, palliative care and chronic illness; (3) older persons, social inclusion; and (4) mental health and disabilities. In addition, PCCC is

responsible for 32 Local Health Offices, each of which is manned by a Local Health Manager. These local offices are key elements in the management and development of services at a local level. They provide an essential bridge between the national and regional dimension to the local dimension.

3. The National Hospitals Office, which is responsible for the management of the 53 hospitals that exist throughout the country. This is done through a group of 8 network managers, two in each of the four geographic areas, each of which has responsibility for a group of hospital services in his / her area. These network managers, together with the local health managers in PCCC, are key health service development and management stakeholders. In addition the NHO is responsible for pre hospital emergency care, which includes the ambulance service; contracts and utilisation; quality, risk and consumer affairs; planning and development.

The establishment of the HSE has implications for the role of the DoHC. The role of the DoHC now is to support the Minister and the democratic process by:

- Formulating policy underpinned by an evidence-based approach and providing direction on national health priorities ensuring that quality and value for money are enhanced through the implementation of an evidence-based approach underpinned by monitoring and evaluation
- Protecting the interests of patients and consumers and supporting practitioners and professionals to practise to the highest standards by providing a prudent and appropriate regulatory framework
- Providing effective stewardship over health resources by demanding accountability for achieving outcomes including financial, managerial and clinical accountability, and by providing the frameworks, including enhanced service planning at national level to improve the overall governance of the health system
- Fulfilling obligations in relation to the EU, the WHO, the Council of Europe and other international bodies and the continued implementation of the

co-operation agenda decided by the North-South Ministerial Council (DoHC, 2003a).

In August 2005, Professor Brendan Drumm took up the post of Chief Executive Officer of the HSE (DoHC, 2005b). The new CEO stated that one of his goals was to simplify the health system so that it will be easier for people to access the services on offer. His number one priority was the development of integrated clinical and administrative teams. Other specific priorities include enhancing the role of nurses, including an increase in the number of clinical nurse and midwife specialists in many areas as the team based approach is further developed.

An important addition to the structural reform of the health services contained in the recommendations of the *Prospectus Report* was the creation of the Health Information and Quality Authority (HIQA). In May 2005, the Minister for Health and Children established the Interim Health Information and Quality Authority (iHIQA) under Statutory Instrument No. 132 of 2005 (DoHC, 2005c) with responsibility for making the administrative and organisational plans for the establishment of HIQA. Following the signing into law of the *Health Act 2007* (Government of Ireland, 2007b), HIQA was established on a statutory basis in May 2007. HIQA is responsible for driving quality and safety in Ireland's health and social care services through -

- Setting Standards in Health and Social Services
- Monitoring Healthcare Quality
- Social Services Inspectorate
- Health Technology Assessment
- Health Information

HIQA's work spans the entire health and social services system, with the exception of Mental Health Services, which is the responsibility of the Mental Health Commission. The creation of HIQA was seen as a significant step on the road to a significant improvement in the quality of health services in Ireland. In March 2007, a *News Update* from the then *interim* Health Information and Quality Authority (iHIQA, 2007) reported on the supporting role it would play in

the new Commission on Patient Safety and Quality Assurance, established by the Minister for Health and Children. The Commission was being asked to report to the Minister within 18 months with proposals for greater accountability within the Irish health system in relation to patient safety, including reporting on 'adverse clinical events', a system for licensing public and private providers for healthcare and better integration of the work of the different regulatory bodies in the health system.

The work of the Commission on Patient Safety and Quality Assurance follows on from the publication of the report on the findings of Professor Des O'Neill, Consultant Gerontologist, on the problems at Leas Cross Nursing Home (HSE, 2006a), which brought the question of patient safety very sharply into the public domain.

A practical example of how this is already happening is provided in a report in the *Irish Times* of a case where a woman's diagnosis of breast cancer was delayed by 18 months because of test errors at University College Hospital Galway (Hayes & Carroll, 2007). An independent review was commissioned of pathology services at the Galway Hospital, conducted by the HIQA.

The reform of structures in the Irish health services has been driven by the fundamental principle of separation of policy and executive functions. The separation of the Policy and Executive functions is based on the recommendations made in the *Prospectus Report* (DoHC, 2003b). While the HSRP (DoHC, 2003a) represented the most significant move to reform the health services in Ireland in over 30 years, it was not the first time that moves had been made to separate policy and executive functions. The last major reform of the health services took place on foot of the *Health Act 1970* (Government of Ireland, 1970), which saw the introduction of the eight health boards (Barrington, 1987). Over the years since then a number of initiatives have taken place, the most important of which have been (O'Hara, 1998):

1986 *Health: The Wider Dimensions* (DoH, 1986) – This was in response to the WHO Objectives set out in *Health for All by the Year 2000* (WHO,

1981) and represented an attempt to set a new direction for the services in order to achieve these objectives.

1989 *Commission on Health Funding* (DoH, 1989) – provided an analysis of the key faults in the organisation of the health services and examined the financing of the services with recommendations on the future funding required.

1990 *Dublin Hospital Initiative Group (Kennedy Reports)* (DoH, 1991) – set up to improve the coordination of hospital services and the integration of hospital and other services in the Dublin area. Recommended the setting up a new authority to replace the Eastern Health Board. It also recommended that the Department of Health should be less involved in the direct management of services and should take a greater role in policy and strategic issues.

1994 *Health Strategy: Shaping a Healthier Future* (DoH, 1994) – a precursor to the HSRP (DoHC, 2003a) – this important document focused on the re-orientation and reshaping of the health services so that improving people's health and quality of life became the primary and unifying focus of the health services.

1997 *Statement of Strategy, DoH* (DoH, 1997a) – the response by the DoH to the Strategic Management Initiative (Government of Ireland, 1994) in the civil service.

1998 *Working for Health and Wellbeing: Strategy Statement 1998-2001* (DoHC, 1998a) – Addresses the challenges faced by the DoHC in service delivery as a result of the *Public Services Management Act of 1997* (Government of Ireland, 1997a) and the *Freedom of Information Act, 1997* (Government of Ireland, 1997b).

The audit of structures and systems in the *Prospectus Report* (DoHC, 2003b) revealed that this system was no longer suitable for the provision of a fully accountable, efficient and effective health service in the twenty first century, and its recommendations, along with those of the other elements of the reform programme, heralded the most comprehensive reform of the health services ever conducted in Ireland.

This situation must be contrasted with what has been happening in the NHS over the last 20 years. The 1980s saw central government make a concerted effort to achieve greater managerial control over the NHS (OHM, 2003a). The major changes during the 1980s were due to the Griffiths inspired reforms in 1985 which were based on the finding that the NHS had so coherent system of management at a local level (Griffiths, 1983). The reforms introduced included:

- A rejection of the 'consensus' style of management by the introduction of general managers in health authorities, hospitals and units. This was done with the intention of strengthening strategic management and accountability by putting place structures for line management and devolved budgets.
- Policy and strategy were separated from management within the NHS by the creation of the Health Service Supervisory Board (responsible for strategic direction) and the NHS Management Board (responsible for management, performance review of regional health authorities, finance).
- Management budgets were introduced into hospitals.
- Information on clinical activity, finance, estate management, staffing, support services and staffing was generated based on the introduction of a package of national performance indicators.
- The NHS Training Authority was established to improve management training and education.

In 1989, the British Government produced a white paper entitled *Working for Patients* (DoH, 1989) which led to:

- An increased emphasis on the separation of policy and executive / management functions with the creation of the NHS Policy Board and the NHS Management Executive.
- The removal of representatives of the health professions and of local authorities from the boards of the health authorities, which were now made to resemble company boards, composed of senior executives and non-executive directors.

- Increased power for local managers in the negotiation of contracts with consultants and in the performance management of consultants.

During the early 1990s, the British Government also introduced the GP contract, performance related pay and the *Patients Charter* (DoH, 1992). Overall there was a greater emphasis on consumer choice and improvements in quality of service. The *National Health Service Community Care Act 1990* (Great Britain, 1990) provided for the creation of an internal market within the health services by separating the financing and purchasing of care from the provision of care. It also provided for the creation of self governing NHS Trusts for the provision of services (acute hospitals, mental health services, ambulance services), and GPs with large practices (initially set at 11,000 patients and later reduced to 5,000) were allowed to apply to become fundholders (OHM, 2003a). There was a gradual move away from the internal market approach, fuelled by evidence that it did not increase consumer choice, and the policy emphasis shifted towards a greater emphasis on improving the health of the population and giving greater priority to primary care (OHM, 2003a), which is very similar to what is happening in the HSE today, in particular through the HSE Transformation Programme (HSE, 2006b).

From 1999 on, the NHS experienced a significant increase in funding under the Labour Government. This was accompanied by what has become known as the modernisation agenda (OHM, 2003a) based on *The NHS Plan: A Plan for Investment, A Plan for Reform* (DoH, 2000). The Plan provided for the provision of a major increase in spending accompanied by a multi-themed agenda of modernisation including greater patient and public involvement; opening up the NHS to alternative providers; new frameworks for raising performance, standards of care and levels of accountability; training and development for staff; and shifting power closer to the front line. All of this was supported by the development and implementation of a comprehensive new Human Resources Strategy and an increased emphasis on the use of technology and multidisciplinary working (OHM, 2003a).

In April 1998, the rolling programme of National Service Frameworks (NSFs) was launched. The NSFs are long term strategies for improving specific areas of care. They set measurable goals within set time-frames. The NSFs were introduced in *The New NHS* (DoH, 1997) and *The First Class Service* (DoH, 1998). *The NHS Plan* (DoH, 2000) emphasised the role of NSFs as drivers in delivering the modernisation agenda. National clinical directors were appointed as experts responsible for the implementation of a designated NSF. Examples of designated areas include: coronary heart disease, mental health, diabetes, cancer and older people. Each NSF is delivered with the assistance of an External Reference Group (ERG) which brings together health professionals, service users and carers, health service managers, partner agencies and other advocates. The ERGs are similar to the Expert Advisory Groups (EAGs) set up by the HSE as part of its *Transformation Programme* (HSE, 2006b).

Much of what is happening now as part of the HSRP (DoHC, 2003a) is very similar to the developments that have taken place in the NHS over the last 20 years.

The separation of policy and executive function represents a fundamental change in the role of the Department of Health and Children. A speech by Michael Scanlan, Secretary General at the DoHC, at the Annual Conference of the National Council for the Professional Development of Nursing and Midwifery in November 2006, entitled 'The Policy Role of the DoHC within the Irish Health Services' (DoHC, 2006), outlined some of the implications of this change in role. He emphasised that policy is ultimately a matter for the Minister, Government or Oireachtas as appropriate. The civil service provide policy advice to Ministers and Government but decisions on policy are ultimately a matter for the political system. The role of the Department therefore is an advisory one in relation to policy formulation. In the development of this policy, Scanlan says, the Department cannot make policy in an ivory tower. It cannot be separated from service delivery.

Scanlan stated that one of the core messages of the *Prospectus Report* (DoHC, 2003b) and the *Brennan Report* (Government of Ireland, 2003) was that the

HSE should focus primarily on service delivery and the Department should have the primary role in policy. He also stated that in practice however, the Department and HSE need to work closely together to test the practicality of policy proposals and to listen if the HSE identify possible policy gaps, to seek greater clarity in policy objectives or to suggest that some aspects of policy need to be changed to meet broader policy objectives. Some of this, he adds, can be achieved through the work of the Expert Advisory Groups (EAGs) created by the HSE (HSE, 2006c). The overall aim, he concludes, is on the one hand to protect the right and obligation of the Minister to make policy and to avoid being parochial or defensive about how policy is formulated.

In December 2006, the HSE launched the *Transformation Programme 2007-2010* (HSE, 2006b). The HSE's Transformation Programme represents the organisation's ambition for the future. The programme was prepared following consultation among staff during 2006 and reflects the views expressed during a series of meetings and events across the organisation. It also reflects the views gathered from engagements with the Board of the HSE. Specifically, the Transformation Programme states that the purpose of the HSE is to enable people to live healthier and more fulfilled lives. The Transformation Programme was intended to provides employees of the HSE with a shared direction and focus that will enable them to achieve their ambition for the future which is that everybody should have easy access to high quality care and services that they have confidence in and staff are proud to provide. In a message from the CEO in the HSE's Newsletter in Summer 2006 (HSE, 2006d) the Chief Executive of the HSE, Prof. Drumm said that services must reach out to patients, surround them, keep them out of acute hospitals and as close to their own homes as possible. He also said that at the same time the local and acute service should be linked together to ensure that patients, GPs, therapists, specialised nurses, advanced paramedics and other health professionals have ready access to specialised expertise on a twenty-four hour per day, seven-days a week basis. The theme of the Transformation Programme therefore is integration of services across the primary acute care continuum.

In 2007, as part of its *Transformation Programme 2007-2010* (HSE, 2006b), the HSE commissioned a detailed review of acute hospital bed-utilisation in hospitals with an emergency department throughout the country (PA Knowledge Ltd., 2007). The aim of the study was to assess the extent to which patients occupying adult medical and surgical acute beds had been inappropriately admitted to those beds, and the extent to which patients occupying adult medical and surgical acute beds could have been treated in a more appropriate setting, and identification of those more appropriate settings. The report identifies some implications for the role of nurses and midwives in the increased provision of community and home based care across all care settings. These include improved access to generalist, specialist and advanced practice nursing and midwife services (in general, midwifery, psychiatric, intellectual disability and children's nursing). There will be a need to increase resources in the community to support the provision of improved access to home care packages, IV therapy in the home, and community nursing to support self-care. Other implications include enhancing the role of nurses and midwives in implementing protocol led discharge, early involvement of community nurses and midwives in planning of patient discharge and transition to non-acute care. There is also a need to focus on health promotion, particularly in relation to diet, physical activity, smoking, alcohol, substance abuse and prevention of illness in the role of the nurse and midwife.

The conclusions and recommendations of the study confirm the HSE's vision of pressing ahead with a policy of integration of community based care and acute care and shifting resources into the community rather than providing more beds in the acute services. The recommendations include:

- Increasing provision of a broad spectrum of community and home based care to avoid admissions, facilitate timely discharge and ensure convenient, patient centred care.
- Increasing access to diagnostics and assessment without admission.
- Increasing the range of non-acute bed-based alternatives available.

- Implementing protocol based discharge planning and use of estimated dates of discharge
- Reviewing internal hospital processes to reduce patient delay.

The review was conducted in 37 hospitals across the eight hospital networks between November 2006 and February 2007 (but excluding the Christmas period). A total of 3,035 patients were randomly sampled out of a population of 8,322 (36%).

Evidence of practical moves towards the integration of primary and acute services was provided by the HSE's *Review of Health Services in the North East* (Teamwork Management Services Ltd, 2006) and reported on in the *Irish Times Health Supplement* (Wall, 2007a). The review was conducted in 2006 by an independent group of consultants (Teamwork Management Services Ltd.) and was charged with developing an action plan for improving safety and achieving better standards for health services in the North East. According to the report in the *Irish Times*, the transformation of services in the North East is to be broadened and accelerated. Up to 40 primary care teams (PCT) are to be developed in the North-East as part of the reconfiguration of primary, community and continuing care services. This amounts to an integration between hospital and community services and is intended to act as a blueprint that could be rolled out in other parts of the country.

It was reported in *Health Matters* (HSE, 2007a) that to support service reconfiguration, an extensive mapping exercise was being undertaken of existing services. The purpose of this exercise was to facilitate the roll-out of 500 PCTs and 130 Social Care Networks throughout the country. In defining the criteria for the establishment of a PCT, the HSE stated that core minimum team members would include: GP, practice nurses, occupational therapists, PHNs, physiotherapists, speech and language therapists, social workers and home help. Extended team members, who would be called upon as required, would include specialists in dietetics, orthodontics and dental. Each PCT will be part of a *Primary and Social Care Network*, which links 3-5 teams with

responsibility for the community based healthcare needs of populations from 30,000 to 50,000 people.

In response to concerns about the lack of integration within the HSE and the establishment of separate pillars for the NHO and the PCCC, the Chief Executive of the HSE, Prof. Brendan Drumm was reported in the *Irish Times Health Supplement* (Wall, 2007a), on the occasion of the roll-out and acceleration of the review and integration of services in the North East, as saying that there would be a significant reconfiguration within the HSE PCCC services, which, he said was essential for the effective reconfiguration of hospital services.

Further evidence of integration of services is the Hospital in the Home (HITH) Initiative, launched by the HSE in March 2007 (Hofman, 2007a). This initiative allows suitable patients to be treated at home rather than in a hospital. The initiative is available to all patients currently attending the six acute hospitals in Dublin, which include the five teaching hospitals (DATHS) and Connolly Hospital in Blanchardstown. Potential users can also be referred through their GP if they are within the Dublin city and county catchment area, or may be transferred to the programme from a hospital or ward once they have stabilised sufficiently. This reduces the risk of patients catching hospital acquired infections, eliminates queues and reduces treatment time. It was estimated that since its establishment (March 2007) over 1,400 bed days had been saved.

Mention should also be made of a number of Community Intervention Teams (CIT) introduced as pilot initiatives in a number of locations throughout the country (2 in Dublin, 1 in Cork and 1 in Limerick) in 2006. It is essentially an 'Out of Hours' nursing service, delivering nursing care in the home, or at a designated wound clinic. The aim is to support people at home, either allowing them to be safely discharged from hospital or to prevent them from needing admission to hospital in the first place. Patients who have been referred to the CIT are managed for a maximum of 10 days and are then referred to the Public Health Nurse service. Patients include older people living alone; people who have had a fall with subsequent fracture, or who need nursing assistance to

administer insulin. Types of nursing care provided include: Blood pressure monitoring, wound dressings (excluding compression dressings), Palliative care, diabetic care, Catheter care, Ostomy care, Percutaneous Endoscopic Gastronomy (PEG) tube care, Respiratory care, medication management, care of Hickman Catheter (HICC) and Peripheral Inserted Central Catheter (PICC) lines, fractures, injections.

There is also evidence of a move towards more midwife led services, involving an enhanced role for the midwife in the community (e.g. through the DOMINO initiative, which involves closer links between the hospital and the community. In 2007, the HSE commissioned a review of maternity services that is expected to provide a clear direction for the strategy of maternity services for the next 10 years (Ingle, 2007).

As part of its Transformation Programme (HSE, 2006b), the HSE has set up a number of Expert Advisory Groups (EAGs). These groups are an integral part of the HSE's quality strategy. They provide a platform for health professionals and service users to participate actively in the programme by influencing and setting operational policy, strategy and quality standards. Participants in the groups include medical consultants, doctors, nurses, therapists, carers, managers, people who use the services, leaders in health and social care, and representatives of the DoHC. To date groups have been set up in the areas of mental health, diabetes, children and elder care, all with the aim of improving quality of care (HSE, 2006c).

As part of the overall reform of structures within the health services, it is possible to identify a move towards increased provision of services by the private sector, with significant political backing for this trend. Public sector hospitals are increasingly using private service providers, and the *National Treatment Purchase Fund* (NTPF) is a good example of the trend towards private sector provision. Established in April 2002, the NTPF is one of the initiatives outlined in the Health Strategy (DoHC, 2001a) to reduce long term waiting lists. If a public patient is over 3 months on a public hospital in-patient waiting list for an operation they can contact the NTPF to discuss options for treatment in a

private hospital. The NTPF sources treatment for qualifying patients in hospitals in Ireland, Northern Ireland and England. Patients who opt for treatment with the NTPF will receive their treatment free of charge. Medical Consultants are now adapting their service provision strategies to take account of this trend. This has fundamentally changed the way in which hospitals deal with waiting list issues. The *Treatment Purchase Fund* has taken away the pressure that existed around the management of waiting lists.

1.3.3 Financial Management

An additional important part of the Health Services Reform Programme was the reform of financial management and control systems. *The Commission on Financial Management and Control Systems in the Health Service* (Government of Ireland, 2003), known as the *Brennan Report*, carried out a detailed examination and review of the financial management and control systems in the Irish health service. The Commission found problems in the existing system and adopted four core principles in addressing these problems:

- The health service should be managed as a national system
- Accountability should rest with those who have the authority to commit the expenditure
- All costs incurred should be capable of being allocated to individual patients
- Good financial management and control should not be seen solely as a finance function.

The 136 recommendations made by the Brennan Commission include:

- The establishment of an Executive to manage the Irish health service as a unitary national service

- A range of reforms to governance and financial management, control and reporting systems to support the Executive in the management of the system
- Substantial rationalisation of existing health agencies
- Strengthening the process of evaluation of clinical and cost effectiveness for publicly funded drug schemes
- Pending the establishment of the Executive, the creation of a high-level and well resourced Implementation Committee (Government of Ireland, 2003).

There is evidence that the recommendations of the Brennan Report are being incorporated into policy and service development. Perhaps the most obvious of these is the creation of the HSE, involving a complete separation of policy and executive functions and charging the DoHC with the role of monitoring and evaluating the work of the HSE and its expenditure. Other practical examples also point to changes in culture. In September 2006, The DoHC announced the establishment of an inter agency group which will seek to ensure value for money on health service projects (Wall, 2006). The group focused initially on areas such as pharmaceuticals, procurement, estate management, employment management and administrative spending. The group also has a role in monitoring adherence to value for money requirements in capital investment expenditure on information and computer technology and on consultancies. The group is chaired by the Secretary General of the DoHC, and includes the Chief Executive of the HSE, the Chief Executive of HIQA and a senior official of the Department of Finance. The group is charged with providing a further level of assurance to the Minister for Health and Children, the Department of Finance and the HSE board that 'value for money' in health spending is getting the required attention. The setting up of the group is directly related to the implementation of the recommendations contained in the *Brennan Report* (Government of Ireland, 2003). In March 2007, it was reported (Wall, 2007b) that the group set up to review value for money in health spending was now looking for savings of €500 million between 2007 and 2010. It was also reported that the money thus saved would be ring-fenced for frontline services.

The savings are to be made from within the annual budget of the HSE which amounts to €14 billion per annum.

Information and communications technology (ICT) has emerged as an important area for development of quality integrated systems within the health services that are transparent and accountable and responsive to patient needs.

Some progress has been made along these lines with the establishment in 2003 of Healthlink Online, which was expanded in 2006 to include a neurology service called Neurolink. Healthlink provides details of a patient's Emergency Department[1] attendance, waiting list notification, radiology results, discharge information and out patient appointments. According to a report in the *Irish Times Health Supplement* of 10th April 2007 (Hofman, 2007b), over 1,000 GPs were registered to the service along with the five DATHS[2], Temple Street Hospital, many acute hospitals, University College Hospital Galway, Mayo General Hospital, Limerick Regional Hospital and Midlands Regional Hospital. The service was expanded in December 2006 in conjunction with St. Vincent's University Hospital, to include Neurolink, an electronic referral system enabling GPs to consult with a neurologist for advice on what tests a patient with a neurological complaint may need. The HSE is also rolling out a laboratory test request service for Healthlink Online and expects the service to handle more than two million messages in 2007.

Of course the potential for ICT uses within the health services go beyond the administrative side of quality and safety into the realm of what is referred to now as eHealth. There are developments in the diagnostics, treatment and monitoring of health care services that are being driven by the possibilities presented by modern technology. This includes the possibility to monitor large

[1] Modern usage recommends the use of the nomenclature *Emergency Department* rather than Accident and Emergency (A&E). However, the term A&E is still used widely throughout literature and the service. In this thesis, the terms are used interchangeably.

[2] The Mater Misericordiae University Hospital, St. Vincent's University Hospital, St. James's Hospital, Beaumont Hospital and AMNCH Tallaght.

complex intensive care units (ICUs) with less personnel and provide remote services to patients. This has significant impacts on both the economics of health care delivery and on the question of maintaining a patient centred approach.

These developments have significant implications for the development of the role of healthcare professionals. With an increased use of remote diagnostics, remote consultation, electronic health records and more technology assisted monitoring; the profile of the kind of health care professional that is required will change significantly. This is something that requires a greater amount of reflection and consideration about the future than it is receiving at the moment.The implications go beyond the realm of the professionals. They also impact on the way we conceive of and design the healthcare environment of the future. In the USA, a good example of how this is being applied to the development of nursing and midwifery is what is known as *The Technology Informatics Guiding Education Reform (TIGER) Initiative* (TIGER, 2007). This initiative is aimed at enabling practicing nurses and midwives to fully engage in what the authors refer to as 'the unfolding digital era of health care'.

1.3.4 Medical Staffing

The final element of the Health Services Reform Programme related to medical staffing. *The Report of the National Task Force on Medical Staffing* (DoHC, 2003c) was published in 2003 under the aegis of a Task Force established in February 2002 by the Minister for Health and Children. The purpose of the Task Force was to devise an implementation plan for reducing substantially the average working hours of non-consultant hospital doctors (NCHDs) to meet the requirements of the European Working Time Directive (EWTD); to plan for the implementation of a consultant-provided service; and to address the medical education and training needs associated with the EWTD and the move to a consultant-provided service. The Task Force's terms of reference charged it with devising, costing and promoting implementation of a new model of hospital service delivery based on appropriately trained doctors providing patients with

the highest quality service, using available resources as equitably, efficiently and effectively as possible.

The Task Force strongly recommended that the normal working day in a range of areas throughout the hospital should be extended, by agreement, to cover a period such as 7 am to 9 pm. This would apply in areas such as out-patient departments, laboratories and day theatres. The exact opening hours would be based on decisions about local service needs, and could be phased in over a period.

The case for greater multi-disciplinary working is growing even stronger as work becomes more specialised and the needs of patients can be met in a range of different ways. The Task Force recommends that multidisciplinary working between health and social care professionals should be fostered, and that this is most likely achievable through close liaison between the universities at undergraduate level and the relevant professional bodies at postgraduate level.

The Task Force examined the scope for introducing or further developing grades of staff that would facilitate a more appropriate distribution of skills and functions. The focus was on grades that would bring genuine opportunities to deliver health care more efficiently, taking account of who should best provide the service required. There was to be no question of simply creating extra grades to take on work that is not seen as attractive to existing staff. Any grades new to the Irish system should:

- Be introduced on the basis of clear protocols, which ensure that patient care is paramount
- Bring substantial and demonstrable opportunities for improved efficiency in the delivery of high quality services
- Be based on a system of structured education and training leading to a recognised qualification
- Work as part of a team within the consultant-provided system proposed in this report.

There are many examples internationally of a range of health care professionals not formally recognised in the Irish system who provide patient care and skilled support to medical and nursing colleagues. They can come from a variety of backgrounds, including medical, nursing and support staff, but they must obtain the relevant recognised qualification to work in a specific capacity in the hospital. Examples include 'physician assistants' who work under the supervision of a fully qualified physician and a number of categories of 'operating department assistants' such as 'surgical assistants', 'anaesthetic assistants' and similar grades of staff.

The Nursing Policy Division of the DoHC produced a nursing response to the report entitled *Report of the National Taskforce on Medical Staffing 2003: The Challenge for Nursing and Midwifery. A Discussion Paper* (DoHC, 2003d). The discussion paper outlines the critical success factors necessary for nursing and midwifery to respond appropriately to the challenges set out by the Task Force, including the development of skills over time, partnership, change management and the development of clinical competence guidelines.

1.4 Other Policy Initiatives

A number of strategies and reports have been published that are of direct relevance for nurses and midwives in the development of their roles. These include:

- The *Cardiovascular Strategy* (DoHC, 1999b)
- *Ireland's Changing Heart: Second Report on Implementation of the Cardiovascular Health Strategy* (DoHC, 2003e)
- The *Health Promotion Strategy* (DoHC, 2000a)
- The *Report of the National Advisory Committee on Palliative Care* (DoHC, 2001b)
- The *National Drugs Strategy* (Department of Tourism, Sport & Recreation, 2001)

- The *Primary Care Strategy* (DoHC, 2001c)
- *The Years Ahead. A Policy for the Elderly* (DoH, 1988).

These policy documents refer to the role of nurses and midwives in education of patients and clients and in promoting a positive approach to health. They also provide the basis for the development of specialist roles in areas such as cardiovascular care, palliative care and work with drug abusers. The reports also refer to the role of the nurse and midwife in both primary and acute settings.

A number of strategies and reports have emerged in recent years that have a direct relevance to the role of psychiatric nurses. The most important of these was *Planning for the Future* (DoH, 1984). In addition, *Health Strategy* (DoHC 2001a), and the *Primary Care Strategy* (DoHC 2001c) contained a number of actions and initiatives of relevance to the provision of psychiatric services. More recently, in 2006 the Government published *A Vision for Change – Report of the Expert Group on Mental Health* Policy (Government of Ireland, 2006). The reports and strategies highlight changes in trends such as the de-institutionalisation of care and the shift towards community based care. They also highlight the fact that there has been an increase in uptake of services, which is expected to continue. This increased uptake of services is attributed to the modernisation of the services, the shift to community based service provision and the decrease in the stigma that has traditionally been associated with psychiatric illness. Other contributing factors include increased consumption of alcohol and drugs and the breakdown in the traditional structures of the family (DoHC 2001a). The *Vision for Change* report also highlights the fact that despite the fact that the majority of services are now shifting to the community, the vast majority of psychiatric nurses are based in institutions. There will be a need to redress this imbalance in the development of services for the future.

In 2001, pursuant to Section 32 of the *Mental Health Act 2001* (Government of Ireland, 2001), the Mental Health Commission was established. This is an independent statutory body. Its principal functions are to promote, encourage

and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under the *Mental Health Act 2001* (Government of Ireland, 2001).

In 2005, the National Office for Suicide Prevention was established by the Health Service Executive following the launch of *Reach Out – A National Strategy for Action on Suicide Prevention* (HSE, 2005).

Other relevant reports include:

- The *National Health Promotion Strategy* (DoHC 2000a)
- *A Plan for Women's Health* (DoH, 1997b).
- The *Report of the National Task Force on Suicide* (DoHC, 1998b).
- The *National Drugs Strategy* (Department of Tourism, Sport and Recreation, 2001).

There are two reports that are of relevance to children's nursing. The *Children First* report, produced by the DoHC in 1999, contained national guidelines for the protection and welfare of children (DoHC, 1999a). The principal focus of this report was to focus all healthcare providers on their duty to protect children. It provided guidance on the different types of abuse, how to report suspected incidents, and how to treat and care for vulnerable children. The *National Children's Strategy* (Government of Ireland, 2000) identified 14 objectives to meet the needs of children. These objectives were divided into three principal national goals:

- Satisfaction of a basic range of needs for all children
- Identification of children who have additional needs
- Recognising that all children need the support of family and community.

All of these policy initiatives point to a increase shift to the provision of community based services and to an expectation that nurses and midwives will play an important role in the development and delivery of these services.

1.5 Conclusion

It is possible to identify a number of key conclusions from this review about what health services of the future will be like in Ireland. These can be summarised in the following points:

1. The health services of the future will be delivered to a population that is wealthier, with higher expectations about what they can expect from public services. This will increase pressure for continued investment in both capital and current spending on health services.

2. Ireland's population will continue to grow at a fast rate and the birth rate will continue to increase. The number of older people will increase with implications for dependency relationships from both a social and an economic perspective.

3. Increased labour force participation by women together with an increase in the number of dependent older people will have implications for the traditional care structures that existed within families. This will have implications for the provision of community based primary care services. The bulk of the demands in this area will fall on nurses and midwives, who make up the largest portion of the labour force in the health services.

4. Increased wealth will bring with it an increase in lifestyle diseases such as obesity, diabetes and drug-related illnesses. Conversely, there will continue to be poverty related diseases social problems due to problems of social exclusion and lack of participation.

5. The population of Ireland will continue to become more ethnically and culturally diverse. This has significant implications for the delivery of services and in particular the need for sensitivity to cultural differences and communications issues. It also raises significant questions for the recruitment practices within the services and the need for increased training for professionals and administrators in dealing with a more diverse population and consumer base.

6. The health services of the future will be delivered by an integrated accountable entity. It will lead to a greater degree of accountability within the system. The creation of the HSE should lead to greater equality of access to services and to the development of higher standards in the delivery of services. The HSE is likely to face pressure for increased integration of services and administrative structures and, in particular, to revise the division between the two pillars PCCC and NHO (Appendix 1 and 2). The structures as they are currently configured are more suitable for bureaucratic control and distribution of funding resources than for service delivery management. They are also not conducive to the clinical management of services.

7. In order to make progress in the integration of services, there is a need to review the involvement of clinical leaders at all levels of the health service delivery structures. This may require the creation of posts at national and regional level for clinical coordination, involving hospitals and primary care teams. The involvement of clinicians and the integration of services is essential to ensure clinical safety throughout all of the activities of the HSE A clustering system may be appropriate with a view to bringing together primary care and hospital structures within regional and local geographic areas.

8. The creation of the HSE has significant implications for the role of the DoHC. Its role changes from one of resource management to one that focuses on policy, protection of the public and performance management. This will require the development of procedures and protocols to ensure clinical safety is an integral part of the policy making and performance management process. This has significant implications for the culture and day to day work of those who work in the DoHC and for the relationships that should exist between the DoHC and the HSE.

9. The health services of the future will see acute hospitals focus entirely on major acute interventions. Service delivery will shift to the primary care setting in the community, with an increase in initiatives such as the Hospital

in the Home (HITH) and Community Intervention Teams (CIT). There will be an increase in the availability of diagnostic and assessment services that do not require admission to hospitals. Length of stay in hospital will be shorter and there will be more protocol based early discharge arrangements in place. Professionals will follow up with the patient in the community.

10. There will be an increase in the provision of private health services. Consumers will be offered and will avail of greater choice.

11. Standards in both private and public health care provision will be driven by HIQA and the respective regulatory bodies of the different professions. This will mean a significant increase in the quantity and intensity of audit within the system, with consequences for the way professionals account for their work. The health services of the future will be delivered with a very high emphasis on personal and professional accountability within the system. This has significant implications for managers and clinical professionals within the system, who will expect to be accountable for their area of service delivery and be called to account for the quality nd value for money of the services they provide.

12. The services of the future will be driven by a greater and more wide spread use of technology, in particular information and communications technology. This will lead to an increase in the level of technology-driven services, the availability of e-health options and the networking of professionals and systems across institutional boundaries. It will underpin the increased emphasis on community-based services and remote consultation.

These conclusions will provide a backdrop against which to assess the results of the primary research on the future of the health services that will be discussed in chapter 5.

Chapter 2 – The Development of Nursing and Midwifery in Ireland

2.1 Introduction

The previous chapter described the context in which nursing and midwifery operate in Ireland. It is clear from that analysis that the professions face considerable challenges in meeting the emerging expectations and needs of society and of the health services. This chapter will seek to take stock of where nursing and midwifery in Ireland is at the moment as it faces the contextual challenges that have been identified.

The development of a statutory based system of self-regulation that requires nurses and midwives to be eligible for inclusion on a Register is at the base of the professionalism of nursing and midwifery. This has developed over the years in response to service and professional developments, culminating most recently in a radical review of the role of nursing and midwifery by the Commission on Nursing (Government of Ireland, 1998). This review had profound implications for the development of the professions and of the role of nurses and midwives in the health services. It has resulted in the introduction of a number of significant changes in the professions, in particular the introduction of a clinical career pathway, the development of which is the responsibility of the National Council for the Professional Development of Nursing and Midwifery (National Council).

Developments in the role have included the emergence of an increased amount of nurse and midwife led services, the involvement of nurses and midwives in prescribing and significant changes in the demands being placed on nurse and midwife managers. There has also been a radical transformation in the provision of educational opportunities for nurses and midwives, both at pre-registration and post-registration levels, including increased professional development opportunities. Recent developments have also included an

increased emphasis on the creation of joint appointments between clinical and educational settings.

Finally, with so many radical developments happening in nursing and midwifery in Ireland, and in particular with the emergence of increased importance of specialisation and advanced practice, it is opportune to reflect on what is the essence of nursing as it seeks to adapt to the increasing demands of the social, demographic, epidemiological and policy context within which it operates. The chapter will conclude with a reflection on this theme with the intention of setting out certain fundamental principles that should be borne in mind when discussing future strategies for the development of the profession.

2.2 The Divisions of the Register

The Nurses Registration Act 1919 (Government of Ireland, 1919) provided nursing and midwifery with its first statutory basis and established for the first time a register of general nurses. *The Nurses Acts 1950*, *1961*, and *1985* (Government of Ireland, 1950, 1961 and 1985) retained this register, and these acts formalised the authority under which general nurses could practice (National Council, 2003a).

There are a number of divisions of the Register of Nurses maintained by An Bord Altranais. The principal divisions are: General Nursing, Midwifery, Psychiatric Nursing, Intellectual Disability Nursing, Children's Nursing, and Public Health Nursing. The number of individuals registered at the end of 2005 in each of these Divisions are (An Bord Altranais, 2005a): General – 66,153; Midwifery – 17,061; Psychiatric – 11,793; Children's – 4,744; Intellectual Disability – 4,473; Public Health – 2,675.

General nurse training has seen much development and increasing academic recognition. Since 2002, pre-registration education for entry to the register is at degree level. According to Treacy & Hyde (2003), the introduction of the four year degree programme for pre-registration education of nurses in 2002, on

foot of a recommendation by the Commission on Nursing, was the first time that *officialdom* had created the conditions for making nursing education visible, and indirectly, the contribution that nursing could make to healthcare.

The Report of the Commission on Nursing (Government of Ireland, 1998) recognised the distinct identities of nursing and midwifery. The report states that "The Commission acknowledges the request from midwives for recognition of their distinct identity and recommends that the title of the amending legislation should be the Nurses and Midwives Act." (Government of Ireland, 1998, p. 65). Since the publication of that report we now talk in Ireland of the professions of nursing and midwifery as separate but related. At the time of writing, in October 2007, the Nurses Act 1985 has not been amended, however a Draft Bill is in preparation that will include a reference to midwifery as distinct.

The accepted international definition of the midwife in Ireland is the one that has been adopted by the International Confederation of Midwives (ICM), the International Federation of Gynaecology and Obstetrics (FIGO) and the World Health Organisation (WHO) (1992). This definition is endorsed by An Bord Altranais (An Bord Altranais 2000a).

The *Report of the Commission on Nursing* (Government of Ireland, 1998) identified the midwifery profession as distinct from nursing, with exclusive skills in relation to maternity care, yet many midwives feel confined by obstetric practices (Government of Ireland 1998). Midwifery-led care has long been an aspiration of midwives and women in Ireland (DoH 1997b). The *Report of the Maternity Review Group* in the former North Eastern Health Board (NEHB) proposed the setting up of two midwife led units attached to conventional maternity units in the NEHB (NEHB, 2001). Two such units were opened in July 2004 and are currently being evaluated. Many midwives have stated that they are now actively seeking opportunities to practise midwifery within settings that provide autonomy and alternative choices in childbirth (Government of Ireland 1998, An Bord Altranais 2001). There are examples of innovative community practice taking place at present, such as the service provided by the Southern Health Area (SHA), which employs independent midwives to provide

domiciliary maternity services. The evaluation of the pilot scheme DOMINO (Domiciliary care In and Out of Hospital) in the National Maternity Hospital showed that it was extremely successful and viable and, given sufficient funding, was sustainable in the long term (Community Midwifery Service, National Maternity Hospital, 2001). The evaluation made a strong case for the development of similar schemes in other Dublin maternity hospitals and other units around the country.

Until recently the only pathway to becoming a midwife was to undertake general nursing, followed by a two year post-registration diploma programme. A direct entry degree programme in Midwifery commenced in September 2006. This builds on the direct entry midwifery education pilot programme that was developed and delivered in partnership between Trinity College, Dublin, the Rotunda Hospital, Dublin and Our Lady of Lourdes Hospital, Drogheda from 2000 to 2003. This pilot project followed on from a recommendation of the Commission on Nursing (Government of Ireland, 1998). In conjunction with this development, the post-registration programme has been decreased to 18 months.

The first major move towards the professionalisation of psychiatric nursing in Ireland came towards the end of the nineteenth century when the Medico-Psychological Association began to coordinate the training of psychiatric nurses. In 1919, under the *Nurses Registration Act* (Government of Ireland, 1919), a supplementary part of the General Nursing Council register was established for mental nurses and the first entry was made to this register in 1921 (National Council, 2003a).

The publication of the policy report, *Planning for the Future* (Department of Health (DoH), 1984), set out the blueprint for development of a community mental health service in Ireland. This report outlined major changes in the mental health services, notably moving the delivery of in-patient services from large psychiatric hospitals to units in general hospitals. There was a greater emphasis on rehabilitation of the mentally ill and a relocation of services into mainstream medical care and especially the community. This shift in policy

represented a major change in the role of psychiatric nurses and provided a unique opportunity for development of skills and roles (Sheridan, 2000). The publication in 2006 of the most recent policy review for psychiatric services, *A Vision for Change – Report of the Expert Group on Mental Health Policy* (Government of Ireland, 2006) emphasised the importance of the community based dimension of psychiatric care through the promotion of the concept of Community Mental Health Teams (CMTH), consisting of multidisciplinary teams of professionals providing services within their catchment area.

Psychiatric nursing is a division of An Bord Altranais' register, through rules made in accordance with the *Nurses Act, 1985* (Government of Ireland, 1985). In 1986, the training programme was revised to reflect mental health trends of the time, and this included a larger proportion of clinical practice experience in the community (An Bord Altranais, 1994). In 1994, a diploma in nursing programme was set up in the Western Health Board, in conjunction with the National University of Ireland, Galway, and was extended to all schools of nursing, including psychiatry in the following four years. In 2002, along with general and 'mental handicap' nursing, the first pre-registration degree programme commenced in psychiatric nursing.

The *Nurses' Rules, 2004* also gave effect to a change in the title used by nurses in this division of the Register (An Bord Altranais 2005b). From then on the title Registered Nurse Mental Handicap (RNMH) was replaced with the title Registered Nurse Intellectual Disability (RNID).

RNIDs provide a range of services across a wide variety of locations, addressing the particular and complex needs of their clients, and requiring particular skills and personal qualities distinct from those in other disciplines of nursing. The development of special services for people with mental handicap did not get underway properly until the late 1950s. In 1955 the DoH requested An Bord Altranais to consider the need for a three-year course in Intellectual Disability Nursing (Robins, 2000). The register for RNMHs was established and the first training schools offering a three-year course in mental handicap nursing opened in 1959 (Government of Ireland, 1998). Mental handicap nursing in the

early 1960s focused on the treatment and care of the severely disabled of all ages, the treatment, care and training of the lower ranges of moderately disabled children and moderately and mildly disabled adults and of others with mental handicaps (DoH, 1965). More schools of mental handicap nursing were established from that time until 2002, and the syllabus of training has been revised on several occasions to reflect trends in care and service provision (Chavasse, 2000). In 2002, along with general and psychiatric nursing, the first pre-registration degree programme commenced in mental handicap nursing (now referred to as intellectual disability nursing).

Specialist hospitals for the care of sick infants and children have featured in Irish healthcare for well over a century, and this is evident in the founding of what became known as The National Children's Hospital in Harcourt Street, in 1821, followed by the founding of The Children's Hospital, Temple Street in 1872. A third children's hospital, Our Lady's Hospital for Sick Children, was founded in 1956, in Crumlin (Kelleher & Musgrave, 2000).

In 1883 the first school of paediatric nurse education was established in Temple Street Hospital, Dublin. This was followed by a second school in 1884, located in the National Children's Hospital. It was not until 1957 that the School of Nursing in Our Lady's Hospital for Sick Children was established (Kelleher & Musgrave, 2000). The model of nurse education provided was the traditional apprenticeship model, and the first registerable qualifications in sick children's nursing were recorded with An Bord Altranais in 1922. The duration of these courses varied in length and the documentary evidence available reflects the changing structure of these courses from the early 1950s to the present day (National Council, 2003a).

A three-year programme leading to registration as a Registered Sick Children's Nurse (RSCN) was introduced during the early 1950s. This was followed in the early 1970s by the commencement of a four-year programme, leading to combined registration in both the sick children's and general divisions of the register. Both programmes were phased out. The rationale cited for phasing out the three-year programme included problems encountered by singly qualified

paediatric nurses in finding employment outside the greater Dublin region, and outside Ireland (Kelleher & Musgrave 2000, DoHC 2000b). The four-year programme was phased out in the late 1980s and early 1990s, due to a reduction in the number of applicants, and also due to the success of the post-registration programme, which over the years has developed and is now a higher diploma or post-graduate diploma of eighteen months' duration. Many paediatric nurses currently working in centres outside Dublin are required to hold an additional registerable qualification, usually in general nursing (National Council, 2003a). A direct entry degree programme leading to a degree in Children's Nursing and General Nursing commenced in September 2006. Also, from this date, the duration of the post-registration higher diploma programme was reduced to a one-year.

The *Nurses Rules, 2004* were signed by the Minister for Health and Children on the 7th December 2004 (An Bord Altranais, 2005a). This gave effect to a change in the title used by nurses in this division of the Register. From then on the title Registered Sick Children's Nurse was replaced with the title Registered Children's Nurse (RCN).

Public health has been described as organised social and political effort and health promotion for the benefit of populations, families and individuals (National Council, 2003a). The Public Health Nurse (PHN) practises as part of a multidisciplinary team to deliver domiciliary care (Department of Health, Social Services and Public Safety (DHSSPS) / DoHC, 2003). There are over 2,000 PHNs on the active register (An Bord Altranais, 2005a), making them the largest group of professionals working in the community.

PHNs have a wide remit encompassing primary, secondary and tertiary care at three levels including individual, family and community (Hanafin et al, 2002). They have responsibility for the provision of a nursing service in the community to multiple client groups with any type of condition, and public health nursing is an amalgamation of services incorporating midwifery, public health and home nursing (National Council, 2003a).

The role is threefold, combining that of manager, clinician and health promoter (Hanafin, 1997). Their wide range of abilities and responsibilities are reflected in the educational and experiential preparation required to register as a PHN. This takes a minimum of eight years, as the PHN until recently had to be a registered general nurse, a registered midwife, have obtained a Higher Diploma in Public Health Nursing and, in addition, have a minimum of two years experience in clinical practice (National Council, 2003a). The *Nurses' Rules 2004* have removed the requirement for a midwifery qualification and substituted a module in maternity and child health (An Bord Altranais, 2005a).

The Report of the Commission on Nursing (Government of Ireland, 1998) re-examined the public health nursing service in Ireland in terms of its organisation, delivery and focus. Recommendations included the need to develop a coherent vision for the future direction of nursing and midwifery in the community, which reflects the needs of the community (National Council, 2003a).

In 2005, the National Council published a review of the implications for Public Health Nursing of developments in health policy and changes in nursing and midwifery. This review was entitled *Agenda for the Future Professional Development of Public Health Nursing* (National Council, 2005a).

2.3 The Development of the Role of Nursing and Midwifery

2.3.1 The Commission on Nursing

The Report of the Commission on Nursing (Government of Ireland, 1998) represented the most comprehensive review of nursing and midwifery ever conducted in Ireland. The Commission was established on foot of a policy recommendation by the Government of the day, following a period of considerable industrial unrest within nursing and midwifery about the conditions under which they were employed, the career development options open to them, the nature and range of educational services available and the general perception of the profession. In 1997 nurses voted for strike action. The strike

was averted by the setting up the Commission on Nursing by the Minister for Health, Mr. Michael Noonan, on 21 March 1997, following a recommendation from the Labour Court (Labour Court, 1997).

The agreed terms of reference were as follows:

The Commission will examine and report on the role of nurses in the health services including –

- *The evolving role of nurses, reflecting their professional development and their role in the overall management of services*
- *Promotional opportunities and related difficulties*
- *Structural and work changes appropriate for the effective and efficient discharge of that role*
- *The requirements placed on nurses, both in training and the delivery of services*
- *Segmentation of the grade*
- *Training and educational requirements (Government of Ireland, 1998).*

The terms of reference also stated that in its recommendations, it should seek *to provide a secure basis for the further development of nursing in the context of anticipated changes in health services, their organisation and delivery.*

In light of discussions during the consultation process undertaken by the Commission and following agreement by An Bord Altranais, the Commission sought an extension of its terms of reference to include –

- *The role and function of An Bord Altranais generally, including inter alia, education and professional development, regulation and protection of the citizen* (Government of Ireland, 1998).

The newly appointed Minister for Health and Children, Mr. Brian Cowen, agreed to the above on 12 September 1997.

One of the recommendations of the Commission was that a monitoring committee would be established which would issue yearly reports.[3] It was envisaged that recommendations without a suggested timescale would be implemented as soon as practicable and in any event by the end of 2002. In addition to timescales identified in the report, the Commission identified four recommendations as urgent. These were:

1. The establishment of the Nursing Education Forum (for Pre-Registration Education)
2. The establishment of the National Council (for Post-Registration Education)
3. The establishment of the Nursing and Midwifery Planning and Development Units (NMPDUs) in each Health Board (all of which should be established at the earliest possible date)
4. The introduction of legislation amending the *Nurses Act 1985* (Government of Ireland, 1985), which should be introduced before the Oireachtas by early 1999 (Government of Ireland, 1998)

The Commission provided a comprehensive framework, which it referred to as a *blueprint*, for the development of the profession into the future. This included the creation of a number of new bodies with responsibility for the development of the profession such as the Nursing Policy Division in the DoHC, the Nursing and Midwifery Planning and Development Units (NMPDUs) and the National Council for the Professional Development of Nursing and Midwifery (National Council). Two of the most far reaching recommendations of the Commission included the introduction of a pre-registration degree programme for nurses and midwives at the point of entry to the professions, and the determination of a comprehensive clinical career pathway, from generalist nurse / midwife to clinical nurse / midwife specialist (CNS / CMS)) and advanced nurse / midwife practitioner (ANP / AMP). The implementation of these recommendations has transformed the profession in recent years and promises to provide a platform for the further development of the contribution of the profession to the health services of the future. Appendix 3 contains a summary of progress in the implementation of the recommendations of the Commission on Nursing.

[3] The Monitoring Committee was established and held its first meeting on 1 February 2000.

Appendix 4 contains an extract from the speech given by the Minister for Health and Children, Mr. Brian Cowen, on the occasion of the publication of the Report of the Commission on Nursing (Government of Ireland, 1998), at Dublin Castle, on the 16th September 1998 (DoHC, 1998c). In his speech, the Minister referred to the vacuum that had existed in providing direction to the profession of nursing and midwifery and the impact that the Report would have on freeing the profession from controls, practices and attitudes that have held nursing back and prevented it from achieving its full potential in the health services and in society.

2.3.2 Clinical Career Pathway

Responsibility for the development of the role of nursing and midwifery in Ireland in the wake of the recommendations of the Commission on Nursing, lies with the National Council for the Professional Development of Nursing and Midwifery (National Council). The National Council was established on foot of a recommendation of the Commission on Nursing (Government of Ireland, 1998) by *Statutory Instrument No. 376 of 1999* (DoHC, 1999c). It is an independent statutory agency with responsibility for post-registration professional development of nursing and midwifery (Government of Ireland, 1998). The Commission on Nursing recommended that the National Council would be responsible for the development of a clinical career pathway for nurses and midwives.

The clinical career pathway is designed to ensure that nurses and midwives can fulfil their professional role within a range of care settings and working at different levels of clinical autonomy. These roles include those of the staff nurse / staff midwife, the specialist nurse / midwife (CNS / CMS) and the advanced nurse / midwife practitioner (National Council, 2006a). The respective roles of staff nurses / midwives, CNS / CMS, ANP / AMP are distinguished by their scope of practice, educational preparation and levels of clinical decision making, responsibility and autonomy.

The National Council is responsible for the determination of the appropriate level of qualification and experience necessary for entry into specialist practice and advanced practice for nursing and midwifery (Government of Ireland, 1998). In addition, the National Council provides a range of professional development and support services appropriate to each step on the clinical career pathway (National Council, 2006a). These include the provision of funding to support additional continuing educational initiatives for nurses and midwives in cooperation with the NMPDUs. The National Council also works closely with the NMPDUs on a wide range of strategic development issues which include the development of clinical specialist and advanced practitioner posts and the promotion of research in nursing and midwifery. The National Council has also taken the lead in the development of important policy initiatives such as the involvement of nurses and midwives in prescribing medicinal preparations (in partnership with An Bord Altranais), the promotion of research in nursing and midwifery (in partnership with the HRB), the promotion of the development of educational programmes to support the clinical career pathway (in partnership with third level institutions and the Centres of Nurse and Midwife Education). In addition, the National Council also provides a range of master classes and seminars on nursing and midwifery topics, including organising an annual conference on professional development issues, and the development of an interactive portal website, that acts as host for a wide range of nursing and midwifery specialist interest groups. The National Council is also involved in the provision of extensive professional advice at individual and organisational level.

The work of the National Council is articulated in a series of publications that provide guidance and frameworks for professional development. Appendix 5 provides a summary of the principal publications produced by the National Council for the period 2001 to 2006 and provides a description of their relevance for the professional development of nursing and midwifery.

Table 2.1 provides a general reference grid for current career pathways in Nursing and Midwifery. The table has been developed based on the

recommendations contained in the *Report of the Commission on Nursing* (Government of Ireland 1998). Direct entry is now available to all of the branches of the Register for Nursing and Midwifery maintained by An Bord Altranais. The basic qualification for nursing and midwifery is now a degree, which qualifies the individual to be registered as a staff nurse or midwife on the Register. Career path progression is then divided into three general areas – clinical, educational and management. The table provides an outline of the steps along the career pathway for each of the three areas in line with the recommendations of the Commission. Clinical career pathways are divided between acute and primary services. Educational career pathways are divided between the third level sector and the centres for nurse and midwife education (CNEs / CMEs). The management career pathway reflects the recommendations of the Commission for a clearer definition of the various levels of management provided for nursing and midwifery. The *Commission* recommended that there should not be a separate role for research but that this should be integrated into the clinical and academic career pathways. Finally, a report was prepared for the Commission on the question of joint appointments between clinical and academic institutions in nursing and midwifery (Leahy-Warren & Tyrrell, 1998).

Table 2.1 – Current Career Pathways in Nursing and Midwifery

Branch / Division of the Register	General Nursing	Midwifery (since 2006)	Psychiatric Nursing	Intellectual Disability Nursing	Children's Nursing (integrated with General Nursing since 2006)

Entry Qualification	DEGREE			
Role	**REGISTERED STAFF NURSE / MIDWIFE**			
Role Progression	**Clinical (Hospital and Community)**	**Educational**		**Management (Hospital and Community)**
Acute Services	Registered Staff Nurse / Midwife Clinical Nurse / Midwife Specialist Advanced Nurse / Midwife Practitioner (Research)	**Third Level** College Lecturer Statutory Lecturer Senior Lecturer Associate Professor Professor (Research)	**CNE/CME** Clinical Placement Coordinator Practice Development Coordinator Tutor Director of CNE/CME (Research)	CNM1/CMM1 CNM2/CMM2 CNM3/CMM3 Nurse/Midwifery Manager Director of Nursing/Midwifery
Other Roles	**Clinical (Hospital and Community)**	**Management (Hospital and Community)**		
Primary Care	Registered Nurse (General, Psychiatric, Intellectual Disability, Children's) Palliative Nurse Registered Midwife Public Health Nurse Practice Nurse (Research)	Assistant Director of Public Health Nursing Director of Public Health Nursing		
Joint Appointments	**Clinical / Academic Joint Appointments in Nursing and Midwifery**			

There are a number of other role development opportunities for nurses that are not included in the above table but which deserve to be mentioned as of strategic importance to the profession. These include posts in areas of policy development such as:

- Chief Nursing Officer in the DoHC
- Nurse advisors in the DoHC
- Chief Education Officer in An Bord Altranais
- Education Officers in An Bord Altranais

- Chief Executive of National Council
- Head of Professional Development and Continuing Education in the National Council
- Professional Development Officers in the National Council for the Professional Development of Nursing and Midwifery (National Council)
- Directors of the Nursing and Midwifery Planning and Development Units (NMPDU)
- Professional Development Officers in NMPDUs, responsible for such areas as manpower planning, development of educational services
- Director of Nursing and Midwifery Services, HSE
- Director of Nursing and Midwifery (Prescribing), HSE
- Assistant Director of Nursing and Midwifery (Prescribing), HSE

In addition to these roles, there are many nurses in acute and community care settings involved in quality development and quality assurance roles.

The grid presented in table 2.1 depicts a career pathway that is quite vertical in nature, with little apparent integration or cross-over between the various paths. Thus for example the grid does not illustrate the potential for cross over between posts in acute and community settings involving reaching-out and reaching-in activity by nurses and midwives. The future should see an increase in the amount of integration and cross over, in line with the demands of the service for a continuum between acute and primary services (1.3.2). In addition the use of joint appointments will involve more horizontal integration across the pathways. The question of joint appointments is dealt with later in this chapter (2.6).

Career pathways provide nurses and midwives with clear choices in relation to the development of their own careers within the health services. It is important, however, to distinguish this from the more dynamic requirement for role development that responds to changes in health service needs.

Until 1998, there was no framework for developing a clinical career pathway in Ireland (Mac Lellan, 2007), although there were some initiatives at a local level

aimed at developing specialists in nursing. Thus for example in 1996 the first ANP in Ireland was appointed on a pilot basis in an Emergency Department in a Dublin hospital (Griffin and Melby, 2006). At the same time in 1996, a *Tender for Establishment and Provision of Cardiac Surgery Services at St. James's Hospital* in Dublin, contained a proposal to include four nurse practitioner posts as part of the staffing complement (St. James's Hospital, 1996). Mac Lellan identifies the roots of specialism in nursing and midwifery in Ireland in the *Report of the Working Party on General Nursing* (Government of Ireland, 1980), which recommended the appointment of specialist nurses to enhance nursing care by providing specialist nursing advice to other nurses (Condell, 1998). It was the *Report of the Commission on Nursing* (Government of Ireland, 1998) that recommended the establishment of a comprehensive clinical career pathway framework to encourage experienced nurses and midwives to remain in clinical practice and use their expert skills to improve patient outcomes and respond to health policy developments (Mac Lellan, 2007). The clinical career pathway leads from generalist to specialist to advanced practice. Levels on the pathway are linked with levels of educational preparation, responsibility and autonomy, and to different points on a pay scale that reflect different levels of responsibility. Responsibility for the introduction of frameworks and for the monitoring of the pathway lies with the National Council. At the time of writing (October, 2007), total of 81 ANP / AMP Posts have been approved by the National Council and 52 ANP/AMPs have actually been accredited. In addition a total of 1,941 CNS / CMS have been approved (National Council, 2007a). Appendix 6 contains a list of approved ANP / AMP Posts, as of October 2007, and Appendix 7 contains a list of approved CNS / CMS Posts.

Nurse Practitioner posts have been developed in many countries, including the United Kingdom (Castledine, 2003a; Marsden et al, 2003; Jones, 2005), in New South Wales, Western Australia and New Zealand (Australian Nursing and Midwifery Council, 2004; Department of Health Western Australia 2003; Nursing Council of New Zealand, 2001). In all cases the development of these posts is accompanied by the development of appropriate educational programmes. In a report prepared for the Commission on Nursing, Savage described how the role of nurses and midwives had changed in a number of

countries outside Ireland, reflecting the development of specialties, advanced practice and consultancy roles (Savage, 1998).

Castledine (2003a) points out that nurses have been engaging in expanded and extended roles in clinical practice for many years. In Ireland the expansion of practice is governed by the *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais, 2000a and 2000b), which came about as a result of a demand for guidance in the context of the increasing diversity of practice as a result of the introduction of the clinical career pathway (Government of Ireland, 1998) and as a result of the demands and expectations that were being put on nurses and midwives in clinical practice.

The model of clinical career pathway adopted in Ireland (generalist – specialist – advanced practice) is not dissimilar to the *Castledine Specialist Career Model* (Castledine, 2003a), which is based on the identification of four domains of nursing: general, specialist, higher level or advanced and paramedical (Castledine, 1996). In this model 7 stages of specialist practice are identified. The stages of specialist practice according to Castledine (2003a) are each characterised by a description of the achievements expected at each stage. These are:

1. General nurse working in a speciality and a general nurse working with some experience, competency and education in the speciality: this relates to a newly qualified and registered general nurse who starts his or her career in an area of specialist care.
2. General nurse proceeding at early beginner stage to become a recognised Specialist Nurse in a defined specialist area: this relates to a nurse who has developed a special interest and may be acting as a link nurse to a speciality for a particular subject.
3. General nurse developing into a specialist nurse: this relates to a situation where a generalist nurse has chosen a particular specialist field to follow.
4. Recognition as a specialist nurse: this relates to the achievement of being recognised as a Specialist Nurse in a particular field.

5. Refining work as an Expert Specialist Nurse and / or moving to Advanced Specialist Nursing: this represents the first step in moving towards advanced practice.
6. Recognised as an Advanced Nurse Practitioner (also sometimes referred to as a Consultant Nurse).
7. Expert Advanced Nurse Practitioner developing / adding on to experience, knowledge and competency.

In progressing along the stages of specialist practice, Castledine points to the danger of neglecting the basic nursing principles (Castledine, 2004). The nurse's role, according to Castledine, at whatever skill level or mode of specialist functioning, is to help patents with their fundamental nursing needs. As nursing becomes more technical and specialised, there is the danger that it can be taken up with technical outputs and medical targets rather than addressing the basic needs of the patient, which is at the core of nursing (Castledine, 2004).

In Ireland the National Council has defined the criteria and competencies for recognition at each stage along the career pathway in the form of a framework for the establishment of posts at clinical nurse specialist and clinical midwife specialist levels (National Council, 2001a, 2004a and 2007b); a framework for the establishment of advanced nurse and advanced midwife practitioner posts (National Council, 2001b, 2004b and 2007c). The National Council has also defined the requirements in terms of educational achievement that are required for recognition at each level of practice (National Council, 2002), including the provision of guidelines for the development of appropriate educational programmes. In addition, the National Council has published a number of position papers on the development of specialist and advanced practitioner roles in Emergency Departments (National Council, 2005b), Intellectual Disability (National Council, 2006b) and in Older Persons Nursing (National Council, 2007d). These position papers provide detailed guidance on the assessment of service need, including detailed guidance on the approach to be adopted in determining the need. The guidance provided on service needs analysis in these papers is in addition to the guidance already provided in the

National Council publication *Service Needs Analysis for Clinical Nurse / Midwife Specialists and Advanced Nurse / Midwife Practitioners* (National Council, 2005c). This paper provided advice and a template on the preparation of a business case to support the development of new roles.

Third level educational institutions have responded to the development of specialism and advanced practice in nursing and midwifery in Ireland through the development of appropriate courses at post graduate level. The National Council has worked closely with these institutions in this task. A good example of this can be seen in the collaborative development of a MSc. Course aimed at preparing Ireland's first AMPs (Begley et al, 2007). A consultative, collaborative process, involving 38 midwives across Ireland was developed and resulted in the generation of the philosophy, aims and content of the course. The key message from the process was the emphasis on normality rather than specialisation in the development of AMPs.

The development of clinical career pathways has also brought to the fore the increasing importance of research in nursing and midwifery. In 2006, The National Council published a *Report on the Baseline Survey of Research Activity in Irish Nursing and Midwifery* (National Council, 2006c). This report provides a picture of nursing and midwifery research activity in Ireland for the period December 2002 to 2004. A number of recommended actions support the recommendations of the *National Research Strategy for Nursing and Midwifery in Ireland* (DoHC, 2003f). Other recommendations are set out for building upon the baseline established by this project. A study to identify research priorities for nursing and midwifery in Ireland was carried out in 2005 (National Council, 2005d).

The development of nurse / midwife led initiatives and the development of the roles of the staff nurse / midwife, the CNS / CMS and the ANP / AMP, has the potential to make a significant contribution to the implementation of the health service reforms. This is recognised in the key reform documents, in particular in the health strategy *Quality and Fairness: A Health System for You* (DoHC,

2001a) and the *Hanly Report* (DoHC, 2003c). The latter comments that the role of the CNS/ CMS is already well defined and sits well with the overall recommendation that the skills of health care professionals should be used to best effect. In a response to the *Hanly Report*, the Nursing Policy Division in the DoHC published *The Challenges for Nursing and Midwifery: a Discussion Paper* (DoHC, 2003d). The NMPDU in the former Mid-Western Health Board (MWHB) published a full report (MWHB, 2003) on the experiences of two regional pilot sites that had been chosen as part of the *Hanly Report's* proposals on the reconfiguration of services. The report includes details of the experiences of running nurse-led clinics in the area.

The EWTD National Implementation Group was set up in early 2005 and is chaired by Dr. Cillian Twomey. The multidisciplinary group has approved over 20 pilot projects across all specialties. The EWTD Nursing and Midwifery Sub-Group was set up in early 2005.

The National Council has published a number of evaluations.

Particular attention should be drawn to the *Evaluation of the Effectiveness of the role of the Clinical Nurse / Midwife Specialist* (National Council, 2004c). This evaluation demonstrated that there existed overwhelming support for the effectiveness of the role of the CNS / CMS.

In addition, the National Council published *A Preliminary Evaluation of the Role of the ANP* (National Council, 2005e). Although limited because of the size of the sample involved, this evaluation provided initial evidence that ANP roles improved patient / client care by providing a holistic service, improving access to healthcare for patients / clients. They have also been widely accepted by patients / clients, nurses, doctors and other members of the multidisciplinary team. At the time of writing, the National Council is planning to undertake a more comprehensive and in-depth evaluation of ANP/AMP (and CNS/CMS roles) that should yield more robust evidence about the effectiveness of their clinical interventions and the cost-effectiveness of the services they provide.

The changes introduced by the Commission on Nursing in relation to clinical career pathway represented a radical transformation of the profession. This transformation however will take time to produce the outcomes that are needed. The first degree cohort of nurses / midwives emerged from the education system in 2006. So in 2007, it is right to say that we are only at the beginning of being able to see what will be the long term impact of the changes in the way in which nurses and midwives are being educated.

Building on these changes, the HSE Transformation Programme 2007-2010 (HSE, 2006b) envisages a crucial role for the staff nurse / midwife, the CNS / CMS and the ANP / AMP. Many other changes are taking place in the role of nurses and midwives throughout the services, including the development of nurse and midwife led services and the prescribing of medications.

2.3.3 Nurse and Midwife Led Services

As the role of nurses and midwives develops there has been an increase in the requirement for and the provision of a wide range of nurse and midwife led services.

The National Council published in 2005 *An Evaluation of the Extent and Nature of Nurse-Led / Midwife-Led Services in Ireland* (National Council, 2005f). Nurse-led / midwife-led care is distinct from nurse / midwife coordinated or nurse / midwife managed services. The evaluation stated that nurse-led care is provided by nurses responsible for case management, which includes comprehensive patient / client assessment, developing, implementing and managing a plan of care, clinical leadership and decision to admit or discharge. Patients / clients will be referred to nurse led services by nurses, midwives or other healthcare professionals, in accordance with collaboratively agreed protocols. Such care requires enhanced skills and knowledge and the nurse will need preparation in both the clinical and management aspects of the role. Such nurses will be practising at an advanced level and may be working in approved specialist or advanced practice roles (National Council, 2005f). The evaluation

identified the type of services that had already been introduced and those that were being planned. Appendix 8 contains a list of the type of nurse-led / midwife-led service that have been introduced in Ireland and the number of years established. Appendix 9 contains a list of type of service that directors of nursing / midwifery are intending to introduce in the future.

The concept of nurse led services is one that arises also in relation to the development of interdisciplinary teams and the development of relationships between primary and acute care settings (see chapter 6). It is worth reflecting however on the fact that it is not a new concept in healthcare. In the NHS, *The NHS Plan: A Plan for Investment, A Plan for Reform* (DoH, 2000) was very explicit about the importance of nurse led services based on the autonomy of the professions. The Plan made reference to the fact that the old hierarchical ways of working are giving way to more flexible team working between different clinical professionals. The Plan identified 10 key roles for nurses and midwives: to order diagnostic investigations, such as pathology tests and X-rays; to make and receive referrals; to admit and discharge patients for specific conditions and within agreed protocols; to manage patients' caseloads for certain conditions (e.g. diabetes or rheumatology); to prescribe medicines and treatments; to carry out a wide range of resuscitation procedures including defibrillation; to perform minor surgery and outpatient procedures; to triage patients using the latest IT to the most appropriate health professional; to take a lead in the way local health services are organised and in the way they are run. Many of these functions are already happening in some services in Ireland and are envisaged as part of the more widespread changes that need to take place within the health services in Ireland as envisaged by the HSE Transformation Programme (HSE, 2006b).

A staff nurse / midwife who chooses to remain in the clinical area can continue to practise as a staff nurse / midwife and develop his or her role in line with the provisions of the *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais, 2000a) and the *Guidelines for Midwives* (An Bord Altranais, 2001). Both the *Scope* and the *Guidelines* documents provide nurses and midwives

with a framework to develop their role with considerable scope for flexibility in the interpretation and focus of that role. These guidelines serve to empower nurses and midwives.

The scope of nursing and midwifery practice is defined as the range of roles, functions, responsibilities and activities that a registered nurse / midwife is educated, competent and has authority to perform (An Bord Altranais, 2000a). The framework was developed following consideration of national and international developments in nursing practice and its aim is to support nurses in the expansion of their scope of practice. The scope of practice is already outlined within the definition of a midwife and within the EEC Council Directive 80/155/EEC of 1980 (Council of European Communities, 1980).

Role development in line with the *Scope* and the *Guidelines* documents must be supported, however, by a programme of continuing professional development (CPD). A detailed analysis of professional development for staff nurses and staff midwives is to be found in the National Council publication *Report on the Continuing Professional Development of Staff Nurses and Staff Midwives* (National Council, 2004d). The report links the demand for role development with the requirement for a lifelong commitment to CPD. The report points to a desire for major change and reform in the Irish healthcare system as evidenced by the health strategy (DoHC 2001a) and the HSRP (DoHC, 2003a). Subsequent reports have re-emphasised and strengthened the rationale for improving the way healthcare is delivered, given the fundamental requirement for accountability and the growing demands to deliver value for money and high quality service to the consumer (Government of Ireland, 2003). Staff nurses and staff midwives are integral to this process of health service-wide change. Employers, through appropriate education and training needs analysis can ensure that relevant professional development activities will be provided in a responsive, planned, coherent and equitable manner.

The principal recommendations contained in the report (National Council, 2004d) can be summarised as follows:

1. Health service providers should ensure that provision of CPD is based on an education and training needs analysis, a fair and equitable distribution and a policy approach to applying for funding.

2. Line managers should ensure that job descriptions are competency-based, that part-time and job sharing staff become a targeted group for career planning, that orientation programmes are provided and that nurses and midwives are encouraged to engage in professional development planning and the use of portfolios. In addition, peer-focused learning activities should be planned.

3. Education providers have a role to play in ensuring fair and equitable provision of CPD opportunities. Access to these programmes should be facilitated through web-based programmes, teleconferencing and modular education programmes. CNEs and CMEs have a major role in planning and delivery of in-service training and education.

4. Individual nurses and midwives have a professional responsibility to engage in CPD activities. This should include the use of personal professional portfolios. They should also be involved in and contribute to ongoing analysis of education and training needs.

In 2005, the National Council conducted a preliminary qualitative evaluation of the role of ANP (National Council, 2005b). It should be pointed out that the methodology for this evaluation was qualitative and based on a small sample, due to the fact that only a limited number of ANPs were actually in post at the time. The report shows that the roles have been successful where they have been introduced. The roles are spread over a wide variety of care areas, indicating that roles have developed in response to health service need. The strong clinical focus of the ANP role identified in the study suggests that one of the original aims of the Commission on Nursing (Government of Ireland, 1998), namely, the retention of expert nurses in direct patient care, has been achieved.

The *Agenda for the Future Professional Development of Nursing and Midwifery* (National Council, 2003a) highlighted areas for development within the nursing and midwifery professions for general, specialist and advanced practice. This document provides the context for such developments. To date, many specialist roles in nursing have developed around symptom management, diseases, treatments and health promotion. There is opportunity to identify other areas for specialist practice, within nursing / midwifery, which support holistic practice and enhance continuity of care. For example, areas such as intensive care units have not yet developed CNS roles. The *Agenda* highlights that access by nurses and patients to consultation, education and specialist or advanced expertise is limited and the clinical career pathway of nurses / midwife is restricted. A CNS/ CMS or ANP/AMP could provide a consultative role, lead and undertake audit, be an educator and carry his or her own caseload. Development of specialist and advanced practice roles should be considered in all areas of nursing and midwifery practice where there is an identified health service need.

The *Agenda* went on to identify how the role of the nurse / midwife could be developed in each of the branches of the profession, providing specialist nursing / midwifery services in a manner that reflects current health policy and responds to patient need. The report points out that it is important that any developments should occur within an integrated service development framework and as part of an interdisciplinary approach to service delivery. Interdisciplinarity is one of the many important themes of the health strategy*, Quality and Fairness* (DoHC, 2001a).

The changes in the health system are taking place in accordance with the four guiding principles of the health strategy. In particular, the development of a quality culture throughout the health system can ensure the provision of homogeneous, high-quality, integrated health care at local, regional and national levels. This involves an interdisciplinary approach and continuous evaluation of the system using techniques such as clinical audit. It also means that information systems must have the capacity to provide feedback to health providers and consumers on the quality of care delivered and received.

Quality and Fairness (DoHC, 2001a) states that professional barriers and structures, job specialisation and the absence of interdisciplinary teams were identified as hindering the integration of services for patients and clients and preventing patients' needs being addressed in an integrated and holistic way. The Health Strategy is clear in its message: the focus needs to be placed on promoting and facilitating the delivery of health care through interprofessional partnership for the benefit of the patient. The need for an interdisciplinary team approach applies not only to acute services, but also to primary care services. The interdisciplinary National Primary Care Task Force was established to drive forward the implementation of the changes and developments set out in the Primary Care Strategy (DoHC, 2001c).

The *Prospectus Report* (DoHC, 2003b), also comments on the need for more integration within the health system, stating that achieving effective integration of services is ultimately a managerial function, in many instances combined with effective team working and inter-professional relationships.

2.3.4 Nurse and Midwife Prescribing

A national study has been conducted on the involvement of nurses and midwives in the prescribing of medicines. It was the Commission on Nursing that identified that greater flexibility was needed around the roles of nurses and midwives in the administration on non-prescribed drugs. The study was a joint undertaking by the National Council for the Professional Development of Nursing and Midwifery and An Bord Altranais. The study is entitled *Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products – Final Report,* (An Bord Altranais and National Council, 2005). The report contained five recommendations, one of which was that prescriptive authority should be extended to nurses and midwives subject to regulation. Legislation to enable nurses and midwives to prescribe has now been prepared. The *Medicines Board (Miscellaneous Provisions) Act, 2006* (Government of

Ireland, 2007c), and its associated regulations (i.e. *The Misuse of Drugs (Amendment) Regulations 2007* (Government of Ireland, 2007d) and *Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007) (Government of Ireland, 2007e))* and the amendment by An Bord Altranais of the relevant rules for nursing and midwifery, and the creation of a new division of the Register will form the basis on which nurse and midwife prescribing can become a reality in 2007 (An Bord Altranais, 2007a). A nurse or midwife who completes the An Bord Altranais approved prescribing education programme (An Bord Altranais, 2007b) and meets the conditions emanating from the legal regulations may apply to An Bord Altranais to be registered in the new Division as a Registered Nurse Prescriber (RNP) (An Bord Altranais, 2007c, 2007d, 2007e). An overview of all of the factors involved in nurse and midwife prescribing was provided in a publication produced by the HSE, in cooperation with DoHC, An Bord Altranais and the National Council entitled *The Introduction of Nurse and Midwife Prescribing in Ireland: An Overview* (HSE, 2007b).

The education programme for nurse and midwife prescribing commenced in April 2007 with the Royal College of Surgeons in Ireland and University College Cork, providing the first programmes for fifty students. The award from both Colleges is a *Certificate in Nursing (Nurse / Midwife Prescribing)* (Minor Award, Level 8 on the NQAI Qualifications Framework).

The *Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products – Final Report* (An Bord Altranais and the National Council, 2005), also contains an analysis of the international experiences of prescribing and expanded medication management by nurses and midwives in the United Kingdom, United States, Canada, New Zealand, Australia and Sweden. The report identified that the key factors that contributed to the introduction of prescriptive authority for nurses and midwives in all of these countries included increasing specialisation of the professions (especially the development of ANPs / AMPs), decreasing numbers of medical practitioners and the need to increase health care accessibility.

The issue of prescription of medication raises the further question of the involvement of nurses and midwives in ordering radiology and laboratory services. At the time of writing, legislation is being finalised to enable nurses, midwives and other professions to order radiology services.

The involvement of nurses and midwives in prescribing therefore is seen as a logical extension of all of the other changes in the delivery of services that are emerging within this research and of the role that nurses and midwives are expected to play within it.

In 2007 a Director of Nursing and Midwifery within the HSE was appointed with specific responsibility to implement nurse / midwife prescribing. Four Assistant Directors of Nursing have also been appointed to assist in this work.

2.3.5 Management in Nursing and Midwifery

The importance of the role of management in nursing and midwifery was highlighted by the Commission on Nursing. As a result of the recommendations of the Commission, a considerable amount of work has been done in recent years on identifying the key competencies that are required of nurse and midwife managers.

The OHM (whose functions have now been integrated into the HSE Performance and Development Unit – www.hseland.ie) has been instrumental in the past in healthcare leadership and management training and this has included nursing and midwifery. Specific initiatives included:

- Development of Personal Development Plans
- A Nursing Competency Framework
- A Mentoring Programme
- Clinicians in Management Initiative

In May 1999, the OHM commissioned a *Research Report on Nursing Competencies* (OHM, 2000) which was published in February 2000. The

initiative was based on a recommendation from the Commission on Nursing that competency based approaches to management focus on the personal characteristics, skills, behaviours, which underpin effective or superior performance (Government of Ireland, 1998). The report set out to: identify and define the competencies which are required for effective nursing management in the Irish health and personal social services; to ensure that the competencies are defined in the light of the future service requirements and the transitional challenges that they pose; and to recommend how these management competencies may be applied to enhance the future performance of nursing services.

The Report identified 21 competencies and divided them into four categories: (1) Top level competencies, such as strategic, visionary thinking and working at a corporate level; (2) Mid-level and (3) Front Line Competencies including setting and managing performance standards and building and leading a team; and (4) Generic Competencies, such as building and maintaining relationships, communication and influencing skills.

In addition, the *Empowerment of Nurses and Midwives Steering Group – An Agenda for Change* established in 2000, had a Management Development Sub-group, which played a key role in leadership for managers. Their initiatives included the following:

- Provision of management development programmes for CNM2s and CNM3s during 2001/2
- Publication of a Guide on Commissioning Management Development Programmes for Front-line and Middle-management in 2002;
- The *Leading an Empowered Organisation (LEO) Programme* was run for 3 Health Boards and evaluated for CNM1s in 2003 (OHM, 2003b)
- *A Diagnostic Exercise on the Development Needs of Directors of Nursing/ Equivalent* was published in 2003 (OHM, 2003c).

In December 2004 the OHM published a directory of *Competency Development Options*, which was intended to complement the existing competency related tools and initiatives for managers in all disciplines within the health services. This included *The Management Competency User Pack for Nurse and Midwife Managers* (OHM, 2004a). This user pack was intended to be of use to employers and managers in raising understanding of the competencies required at this level and provide practical guidance on how these competencies can be developed and enhanced.

One of the flagship programmes of the OHM is The Leadership Development Programme. This is a multi-disciplinary programme that has been running since 1998 and in 2006 a total of 167 Health Service employees had participated in programmes. A number of nurse and midwife managers participated in these programmes (OHM, 2004b).

Further discussion of issues related to the management of nursing and midwifery will be provided in chapter 3 in the sections dealing with empowerment and leadership in nursing.

2.4 Nursing and Midwifery Education

2.4.1 Pre-Registration Education

In a report prepared for the Commission on Nursing, Tyrrell describes developments in pre-registration education in the United Kingdom, Australia, Canada and France (Tyrrell, 1998). This report formed part of the deliberations of the Commission on Nursing, which recommended that pre-registration nurse and midwife education should in future be at degree level. The introduction of degree based pre registration education for nurses and midwives in Ireland has raised a number of issues that require further discussion in the years to come. These include questions such as the advisability of moving towards a common point of entry for the professions versus the maintenance of the current system based on five different points of entry, and an assessment of the implications

of the Bologna Agreement (Appendix 11) for pre registration nursing and midwifery education in Ireland.

The introduction of a common point of entry system for nursing and midwifery in Ireland would reflect what happens in the UK and most other countries with a degree programme for nurse education. The common point of entry would entail all nurse and midwife students sharing a common first year or 18 months at University and then choosing which branch they would take. The advantages of such a system would be the creation of greater interdisciplinary solidarity within the professions and the development of common standards across all the branches of the profession. As it stands, Ireland is the only country that has five separate degree programmes (General Nursing, Psychiatry, Midwifery, Children's Nursing, Intellectual Disability). This is not likely to be sustainable into the future.

In June 2004, An Bord Altranais commissioned a team of researchers from the Nursing and Midwifery Research Unit, School of Nursing, Midwifery and Health Systems, University College Dublin, to undertake a study into the points of entry into Irish Nursing. This study became known as the *Five Points Project* (An Bord Altranais, 2005c) and was concluded in November 2005. The terms of reference of the study included the requirement to examine the rationale for and impact of maintaining the points of entry in respect of general nursing, psychiatric nursing, intellectual disability nursing, children's nursing and midwifery. The study concluded with a series of recommendations that summarise the overall approach to pre-registration entry to nursing and midwifery education that prevails in Ireland today (Appendix 10).

By the year 2010 the Bologna Declaration (European Ministers of Education, 1999) will take effect and that would involve a change to a three year degree programme, followed by a year of internship (Appendix 11). The implementation of the *Bologna Process* and *European Higher Education Area* (Appendix 11) will have significant implications for clinical placements and other elements of the current four year degree programme. Is this an opportune time to conduct

an evaluation of the whole programme? Such a review would present the opportunity to examine again options such as single point of entry to nursing and midwifery, shared common basic education for nurse and midwife students, and the advisability or otherwise of sharing some education with other university based students in areas such as science, medicine and other health disciplines.

In July 2007 it was reported (Wall, 2007c) that the DoHC was to commission a review of the nursing and midwifery degree programme with a view to determining whether the investment has represented value for money for the taxpayer. In making the announcement, the Minister for Health and Children said that to date over €700 million had been spent on the introduction of the degree programme since 2002. The report said that €250 million had been invested in capital facilities and revenue costs were running at €120 million. In addition all post-registration higher diploma / degree programmes are funded to a cost of €26 million per annum approximately. In addition to the thirteen higher education institutions nationally providing education programmes to both undergraduate and post graduate nurses and midwives, continuing nurse education is also provided by 18 Centres for Nurse / Midwife Education throughout the country. All of this investment came about as a result of the recommendations of the Commission on Nursing.

Details of the planned value for money review were set out in a submission made by the HSE to the public service benchmarking body which is examining pay levels for nurses. HSE management told the benchmarking body that the future direction for nurses and midwives would involve empowering them to work in new ways, making better use of their skills while ensuring that developments encompass holistic care and not substitution of medical tasks. The report went on to say that such developments must be driven by service needs and clearly contribute to greater efficiencies within the health services as a whole. HSE management are reported as saying that expanding the role of the nurse / midwife would require service analysis to determine need, investment in educational preparation and skill development, integration of new work practices with the multidisciplinary team, development of appropriate

governance arrangements and evaluation of the expansion in terms of patient and service benefit.

Is it time to conduct a full scale value for money evaluation of the degree programme? Some concern has been voiced however about the advisability of conducting a full scale value for money review just one year after the first cohort of degree students have graduated (O'Brien, 2007). A value for money analysis of its very nature considers quantitative data such as inputs and outputs as a measure of economy and efficiency. It should also include an analysis of outcomes as measures of impact and effectiveness. It is too early yet to determine whether the degree programme has had any impact on the delivery of services. It could also be argued that a full analysis of the impact of the degree programme would require a review based on qualitative data such as patient satisfaction, quality of care and other non quantitative criteria.

Research into the value and impact of education related to patient outcomes has been conducted in the United States in 2003 (Aiken et al, 2003). This research set out to determine whether the educational levels of registered nurses in hospitals had a measurable effect on patient outcomes. The study consisted of an extensive study of the outcomes for surgery patients across 168 hospitals over a 20 month period. The 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 and the odds of failure to rescue. The conclusion of the study was that in hospitals with higher proportions of nurses educated at the baccalaureate level or higher, surgical patients experienced lower mortality and failure to rescue rates.

Any review of pre registration nursing and midwifery education however would necessarily have to look in detail at the benefits and opportunities presented by common point of entry and interdisciplinary education.

The development of interdisciplinary health education is not a new phenomenon. Lavin et al (2001) conducted a historical review to examine the

advances made, nationally and internationally, in interdisciplinary health professional education since the mid 1960s. A team of 9 researchers reviewed 119 articles and divided them by decade into the following subheadings:

- Models – defining the conceptual field, describing the curriculum and programme development, or providing a framework for evaluation
- Courses – focusing on objectives, content areas or innovative methods
- Communications / group-process issues – used to extract guidelines
- International perspectives – leading to the recognition that interdisciplinary health professional education, practice, and research is a global movement.

Lavin et al (2001) also point out the language difficulties associated with the use of terms such as interdisciplinary, multidisciplinary and interprofessional. In practice they recommend that the words be used as synonyms when searching databases for information. They also refer to the World Health Organisation (WHO, 1988) definition of interdisciplinary education – '*The process by which students (or workers) from the health-related occupations with different educational backgrounds learn together during certain periods of their education, with interaction as an important goal, to collaborate in providing promotive, preventative, curative, rehabilitative and other health-related services.'*

Two other reviews of literature and materials on interprofessional education are worth mentioning.

Zwarenstein et al (1999) conducted a systematic review of the evidence base for the effectiveness of interprofessional education, using the guidelines for systematic review developed by the Cochrane Collaboration, whose function is described. Electronic databases (Medline and CINAHL) were searched. The search generated a total of 1,062 articles, of which 83 were selected for detailed review based on their abstracts. The researchers concluded that, based on their reviews, there was no evidence in existence at that time there was no evidence that interprofessional education promoted interprofessional collaboration or

improved client relevant outcomes. They were not saying that there was evidence of the ineffectiveness of interprofessional education for these ends, but just that at the time no evidence existed. The writers therefore encouraged interprofessional education providers to build into trials and projects in this area both quantitative and qualitative evaluations in order to inform understanding of interprofessional education experiences and assessment of their worth.

Barr (2003) conducted a review of arguments for shared learning for health and social care professions in the UK Government workforce and training strategy – collaboration, substitution and accelerated career progression – noting concern expressed by universities and their teachers to clarify ends and means. The review contained a historical analysis of the issues involved, tracing the development of interprofessional education from the 1960s. The review also identified priorities for future research and development in interprofessional education. These include:

- Completing work to establish the evidence base from existing sources
- Setting and regulating standards
- Evaluating selected programmes
- Comparing experience of interprofessional education in different fields
- Preparing the next generation of teachers
- Weighing the implications of national service frameworks
- Building interactive learning into undergraduate interprofessional education
- Involving university teachers in work-based interprofessional education
- Designing a continuum of professional, multiprofessional and interprofessional education
- Related objectives for shared learning to workforce planning

2.4.2 Post-Registration Education

In January 2007 the HSE established a Post-Registration Nursing and Midwifery Education Review Group (PRERG). This Group was charged with the preparation of a comprehensive strategy for the development, delivery and

evaluation of future post-registration nursing and midwifery education. In preparing the terms of reference for the group (Appendix 12), the HSE stated that post-registration nursing and midwifery education included:

- Higher / postgraduate diplomas in nursing and midwifery including both registration and non-registration programmes (this will include public health nursing and midwifery programmes although immediate arrangements for the continuation of the post-registration midwifery programme are being dealt with in a separate working group).
- Masters and doctoral education.

Continuing professional development and education has not been taken into account in the work of this group as the remit for this lies with the CNEs, CMEs and NMPDUs.

In May 2007 the PRERG issued a call for written submissions. Respondents were invited to identify the top five principles that the HSE should adopt in developing a framework for post-registration nursing/midwifery education, to describe any further engagement that the HSE should have with key stakeholders for future planning and to outline structures or processes that are needed to strengthen the relationship between service provision and the educational development of nursing and midwifery staff. Suggestions for the financing of the development and delivery of future programmes were also sought.

A series of consultation workshops were held in June 2007 aimed at consulting with the following four sectors – Education, HSE and Service Providers, Regulatory Bodies and Professional Organisations, Staff Associations (Trade Unions).

The PRERG commissioned a literature review to support and inform its deliberations and recommendations. This review was carried out by a team of researchers at the Catherine McCauley School of Nursing and Midwifery,

University College Cork. An interim report was produced in May 2007 (HSE, 2007c) and a final report was produced in July 2007 (HSE, 2007d).

In conducting the literature review, account was taken of a number of factors that emerged from recent policy and consultation documents, which identify major trends and factors that are likely to impact and influence future changes in health service requirements, and the subsequent need for a nursing and midwifery workforce ready and able to respond to these changes. These key factors can be summarized as follows:

- Demographic changes, including both a general population growth, and a growing older population
- Changes in the health and social status of the population
- New health care technologies and interventions
- New and changing legislation
- Higher expectations of people who utilise health services, and involvement of the public in decision making regarding delivery of health services (user involvement)
- Moves to a population based model of health care laying greater emphasis on primary health care, prevention and health promotion
- The increasing cost of health care provision
- The growing emphasis on collaborative and integrated care, and providing care close to people's homes
- Ongoing concern about recruitment and retention of health care professionals
- The impact of the European Working Time Directives on medical manpower
- Focus on life long learning

The review concluded with a series of recommendations in the areas of practice, education, policy and research (Appendix 13).

2.5 Professional Development of Nursing and Midwifery

In 1997, An Bord Altranais produced a report entitled *Continuing Professional Education for Nurses in Ireland: A Framework* (An Bord Altranais, 1997). The report pre-dates the work of the Commission on Nursing. It defines continuing education as a life-long professional development process which takes place after the completion of the pre-registration nurse education programme. The report also states that continuing education consists of planned learning experiences which are designed to augment the knowledge, skills and attitudes of registered nurses for the enhancement of nursing practice, patient / client care, education, administration and research (An Bord Altranais, 1997).

The National Council defines CPD as *"A lifelong process, which includes both structured and informal activities that may include formal education programmes, participation in journal clubs, case conferencing, clinical supervision, learning sets, preceptorship, mentorship, workshops, distance learning programmes and reflection on practice. CPD encompasses processes, activities and experiences that contribute towards the development of a nurse or midwife, both personally and professionally"* (National Council, 2003a).

The National Council (National Council, 2004d) also adopts the definition of the related concept of lifelong learning as a continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills and understanding they will require throughout their lifetimes, and to apply them with competence, creativity, and enjoyment in all roles, circumstances and environments (Medel Anonuevo et al, 2001).

The National Council (National Council, 2004d) also refers to what are called the components and attributes of competence resulting in effective and/or superior performance as defined by Storey (Storey, 2001). These include practical and technical skills, communication and interpersonal skills, organisational and managerial skills, the ability to practice safely and effectively, utilising evidence-based practice, having a problem-solving approach to care, utilising critical thinking, being part of the multidisciplinary team, demonstrating a professional attitude, accepting responsibility, being accountable for one's practice.

One of the difficulties with the provision of continuing professional education for all nurses and midwives is the question of access. Nurses and midwives working in more remote areas of the country, who have not easy access to Universities, Institutes of Technology of Centres for Nurse Education, find it difficult to get time off to attend educational courses that are held in centres that are far away from their place of work. One possible solution to the problem of local provision and access is the emergence of what has become known as *e*Learning – i.e. web-based initiatives designed to provide access to development opportunities using internet, web based solutions. The "*eLearning Guru"* (HSE, 2007e) provided by the HSE Performance Development website describes a wide range of advantages inherent in this approach.

The website of the National Council (www.ncnm.ie) has adopted some of the principles of *e*Learning as part of its overall communications strategy, by providing access to a wide range of learning opportunities on its website (e.g. medication management programme) and by hosting websites of specialist groups and learning initiatives within nursing and midwifery. The website also contains links to databases such as all-Ireland practice and quality development database, developed in partnership between the National Council and the Northern Ireland Practice and Education Council (NIPEC).

The importance of continuing professional development in the lives of nurses and midwives was one of the motivating factors behind the publication by the National Council of guidelines on portfolio development for nurses and midwives (National Council, 2003b, 2006d).The guidelines are aimed at individual nurses and midwives working at the forefront of healthcare delivery, for the purpose of assisting them to identify, reflect upon and record the contribution they make to direct and indirect care, encouraging them to store records of their development in a coherent and structured manner and providing guidance and information on achieving their individual professional goals within the context of the needs of the health service. The document provides 14 sample record sheets and is accompanied by a CD containing Microsoft Word

versions of the record sheets and an Adobe Acrobat pdf version of the Guidelines.

The National Council has an important role to play in providing nurses and midwives with additional continuing education opportunities that enhance their ability to maximise their potential in their chosen clinical career pathway. Between 2001 and 2006, the National Council disbursed a total of €13.5 million that has been used to fund 641 such initiatives as professional and service developments, courses, seminars and workshops. Over 20,000 nurses and midwives have benefited directly and indirectly from these initiatives (National Council, 2006a).

The funds are disbursed on the basis of applications received via the NMPDUs and assessed in accordance with a set of criteria that has been agreed by the National Council (National Council, 2001c, 2007e). Awards made are subject to conditions such as:

- Acknowledgement of the support of the National Council in any documentation related to the programme
- Delivery of the programme as described in the submission plan
- Timely submission of progress reports
- Submission of evaluation report on completion of the programme
- Availability of project details to to other regions/services on a national basis, if requested, and on the National Council's website
- Sustainability of the outcomes of the project.

Once an award has been made and an initiative has commenced, the promoters are required to submit one or more six-monthly progress reports to confirm that the project is proceeding in line with the project plan outline in the application. A final evaluation is then required to be submitted on completion of the project. In this way accountability in the use of funds is ensured[4].

[4] Details and examples of continuing education programmes funded by the National Council are contained in the Annual Reports of the National Council, the Quarterly Review and in

The examples given provide a brief insight into the wide range of courses and initiatives supported by the National Council in the area of CPD. Other important areas covered by these initiatives include a wide range of programmes and initiatives aimed at management and leadership development, including a range of train the trainers programmes in these areas. The National Council has also produced guidelines for health service providers for the selection of nurses and midwives who might apply for financial support in seeking opportunities to pursue further education (National Council, 2003c).

The National Council has published three reports on future professional development of nursing and midwifery.

The first of these is entitled *Agenda for the Future Professional Development of Nursing and Midwifery* (National Council, 2003a). The National Council conducted a nation-wide consultation from March 2002 to March 2003. Workshops were held with directors of nursing and midwifery, directors of the nursing and midwifery planning and development units, and nurses and midwives from all divisions of the register. A call for submissions yielded 105 written responses. The report benchmarks progress to date for general, midwifery, mental health, children's, intellectual disability and older person nursing and sets the agenda for a debate on options, direction and actions for the future. Continuing professional development emerges as the predominant issue in this report for all areas of nursing and is viewed as vital to developing nursing and midwifery practice in modern health structures.

The second report is entitled *Report on the Continuing Professional Development of Staff Nurses and Staff Midwives* (National Council, 2004d). This report examines CPD issues relevant to staff nurses and staff midwives by reviewing: CPD activities of staff nurses and midwives; competency achievement and maintenance relevant to service need and personal

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National Council for the Professional Development of Nursing and Midwifery – Review of Achievements 2001 to 2006 (National Council, 2006a).

professional development of staff nurses and staff midwives; career choice relevant to CPD and competency of staff nurses and staff midwives. The data collection methods for this report included: a literature review, focus groups and questionnaire. Staff nurses from general, mental health, intellectual disability and children's nursing and staff midwives were invited to participate. Nurses and midwives from cities, towns and rural areas were represented, as were those working in community and in-patient settings. Recommendations are made concerning the development of structures to support CPD for staff nurses and staff midwives. The report contains a detailed table of recommendations that summarises the objectives, the deliverables and the responsibilities of individual stakeholders in this area.

The third report is entitled *Agenda for the Future Professional Development of Public Health Nursing* (National Council, 2005a). A nation-wide consultation was carried out from November 2004 to February 2005. Workshops were held with directors of public health nursing, assistant directors of public health nursing, public health nurses engaged in clinical practice and other key stakeholders. The main concerns expressed by participants related to role clarity, workload demands, variation in service provision and delivery of care, the clinical career pathway, leadership, skill-mix and multidisciplinary team working. The report benchmarks progress to date and sets an agenda for future actions.

The National Council also funded the preparation of *A Strategy for Practice Development* (HSE, 2006e). This project was intended to facilitate the development, dissemination, implementation and evaluation of a practice development strategy. The strategy provides a definition of practice development and gives an account of the development of the practice development team within the NMPDU, including an account of its mission, purpose and strategic aims. The strategic aims of the team include: leadership, guidance and support; practitioner development; development of a framework guide; translating strategic policies, documents and reports to local use.

2.6 Joint Appointments

The potential offered by the use of joint appointments between clinical and academic institutions is something that was commented on and valued by the Commission on Nursing and a separate publication was prepared on the subject as part of the outcomes of the Commission (Leahy-Warren & Tyrrell, 1998). In 2005, the National Council completed a project on the subject of joint appointments (National Council, 2005g). The project commenced in December 2004 and finished in June 2005. On conclusion of the project a report was published that provides guidance in the form of a framework for institutions and individuals involved in making joint appointments between services, voluntary organisations, educational institutions and/or other organisations. The report provides an overview of national and international literature and experiences. The need for clear structures and supports are identified as critical success factors. The National Council has created a framework to assist those involved in planning such roles (National Council, 2005g).

In June 2007, University College Dublin (UCD) College of Life Sciences and School of Nursing, Midwifery and Health Systems, advertised two vacancies for posts of Professor of Clinical Nursing, one in Acute Care Nursing and the second in Palliative Nursing. The appointments were to be joint appointments with the Mater Misericordiae Hospital for the Acute Care Nursing appointment and with Our Lady's Hospice for the Palliative Care appointment.

The role of the Professor of Nursing as advertised includes the following (UCD, 2007):

1. Undertake collaborative interdisciplinary and multidisciplinary research.
2. Facilitate and promote international recognition for the UCD School of Nursing, Midwifery & Health Systems and the Hospital involved (Our Lady's Hospice and Mater Misericordiae University Hospital).
3. Build a research culture in palliative care / acute care nursing at the organisational and at the university level.
4. Build relationships with other cognate professions.

5. Enhance potential of the health care organisation to develop clinical research in palliative nursing / acute care nursing that is explicitly linked to desired outcomes.
6. Provide leadership in palliative nursing / acute care nursing research and education.
7. Disseminate research findings at national and international conferences.
8. Provide a strategic leadership role in education and policy developments in palliative nursing / acute care nursing.
9. Provide interdisciplinary collaboration in education.

These examples are perhaps an indication of much more to come in this area. However it is important to remember that joint appointments require careful planning and support mechanisms. Leahy-Warren & Tyrrell (1998) highlighted the benefits, limitations and the importance of facilitating and supporting the role of the joint appointee in nursing. The Office for Public Management (2001) produced a *Joint Appointments Guide*, which provides guidance on setting up, managing and maintaining joint appointments for health improvement between health organisations and local government. The guide identified the importance of strategic planning as a key to success, indicating that the critical success factors were early planning and clear strategic purpose. Castledine (2003b) pointed out that the pioneering of joint appointments at Manchester University School of Nursing, Midwifery and Health Visiting, provide that the best way of teaching the practice of nursing was to have appropriately clinical lecturers who worked with students in their clinical placements.

The potential exists for the creation of a nursing equivalent of the *'clinician scientist'*. This is something that is used in medicine, whereby an individual works within the clinical area, with a clinical caseload but whose main focus is the development of research. Appointments such as these are promoted and funded by the Health Research Board. There would appear to be opportunities for similar positions to be created in nursing and midwifery.

2.7 The Essence of Nursing

In Ireland at the end of 2007 there were approximately 100 approved Advanced Practice posts and 2,000 clinical nurse or clinical midwife specialists. On the active register maintained by an Bord Altranais at the end of 2005 (An Bord Altranais, 2005b), there were 52,598 general nurses, 13,179 midwives, 9,417 psychiatric nurses, 3,859 children's nurses, 3,890 intellectual disability nurses and 2,173 public health nurses. An increasing number of these nurses and midwives have degrees in nursing and other post registration qualifications. Increasingly they are also involved in a much wider range of continuous professional development activities. However, in their work setting all of them engage in the practice of nursing and midwifery regardless of the level at which they operate.

As the practice of nursing and midwifery develops, it is important to reflect on what is the essence of the work. As we seek to move forward towards the formulation of a strategy for the development of the profession of nursing and midwifery, it is important to have a clear idea of what is meant when we speak of nursing and midwifery.

Florence Nightingale (Nightingale, 1860), in her classic *Notes on Nursing – What it is and what it is not*, speaks of nursing as aiding the reparative process of nature through the proper use of fresh air, light, warmth, cleanliness, quiet and the proper selection and administration of diet. She talks about nursing as the care that puts the patient in the best possible condition for nature to act. She also speaks of taking charge, that is not just doing what is necessary oneself, but to make sure that everyone else does so too. An essential feature of nursing is what she terms 'sound and ready observation'. This is a cumulative process that focuses on the all parts of the body, cognisant of the fact that frequently the patient cannot tell for themselves. Nightingale refers to this as 'the faculty of observation'. Sound and ready observation is, according to Nightingale, essential in a nurse. Thus it is through controlling the environment, providing a wide range of personal services, careful observation and taking

charge that the nurse according to Nightingale, aids the reparative process of nature.

Nightingale's view of nursing is still present in much of modern literature on the role of nurses and midwives, although the emphasis has shifted away from control of the environment to interaction with the individual. This is reflective of the fact that in modern institutional settings, the nurse or midwife is less in control of the environment. In recent times, perhaps the most widely used definition of nursing is the one proposed by Virginia Henderson. According to Henderson, the unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him regain independence as soon as possible (Henderson, 1961).

In 1995, a WHO Expert Committee on Nursing Practice (WHO, 1996) considered the Virginia Henderson definition of nursing, and concluded that while the definition provides a sound foundation for describing nursing as it relates to individuals in a wide range of health care situations, it does not take account of issues arising from the changing orientations of health systems and policies or from the new roles and responsibilities that have evolved for nursing personnel. Nursing roles have changed in response to many factors, including technological advances, the transfer of tasks from medicine to nursing, the expansion of health care coverage through community nursing, the absence of physicians in some areas and the reorientation of health care systems to primary care. In response to these changes, the Committee (WHO, 1996) proposed the following three-part, functional description of nursing:

1. Nursing helps individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work. The nurse requires competence to develop and perform functions that promote and maintain health as well as prevent ill health. Nursing also includes the planning and giving of care during illness and rehabilitation, and

encompasses the physical, mental and social aspects of life as they affect health, illness, disability and dying.

2. Nursing promotes the active involvement of the individual and his or her family, friends, social group and community as appropriate, in all aspects of health care, thus encouraging self-reliance and self determination while promoting a healthy environment.
3. Nursing is both an art and a science. It requires the understanding and application of specific knowledge and skills and it draws on knowledge and techniques derived from the humanities and the physical, social, medical and biological sciences.

The value of this contribution from the WHO is that it provides a good description of the work of a nurse. It is a modern day adaptation of the Nightingale view of the nurse and incorporates Henderson's focus on the individual. It also emphasises the role of the nurse as an educator (of individuals and families), as a promoter of health, and the importance of knowledge and skills, science and expertise.

Other writers have provided deep insights into the philosophy and value system that underpins the role of the nurse. In 1999, Kitson identified what she described as the first essence or essential element in nursing, as the philosophical and moral recognition of nursing as a person-centred activity (Kitson, 1999). This is based on an acknowledgement of the uniqueness of the individual and the need for a set of attitudes and behaviours required for the nurse to operate in a person-centred way. These include: paying attention to detail; uncovering meaning in everyday situations; being attentive and available, reliable and true to promises; understanding the importance of each person's own biography and how he or she is seeking to gain an understanding of what is happening to him or her.

Other commentators and theorists (e.g. Benner, 1984 and Titchen, 1998) have used a variety of approaches to explain how nurses can provide patient centred care. These include the development of 'mutuality', or a demonstration of the nurse's ability to hold an unconditional positive regard for the other person

(Rogers, 1976). It also includes being able to focus in on significant events, conditions or situations that enable the nurse to help each person feel intact (Kitson, 1999). Benner (1984) and Benner et al (1999) elaborate on the powers of observation of the nurse and how these develop over time and experience to enable the 'expert' nurse to exercise 'clinical judgement' based on her experience and observations and to develop 'clinical wisdom' over time. It is part of the nurse's reflective practice (Benner et al, 1999). This, according to Kitson, is part of a nurse's sensing and intuitive role, part of the shared experience between the nurse and the human being that requires nursing, each one sharing the experience, each one recognising the contribution of the other. It is this philosophy, according to Kitson, with which nursing should start and finish.

This complements, but perhaps goes further than, Nightingale's (1860) emphasis on 'sound and ready observation' as being essential in a nurse. In Nightingale the emphasis was on observation of the physical environment and the physical well being of the patient. In this case it extends to the whole person and the human circumstances in the environment. It includes an element of relationship building as being an essential requirement for the nurse to be able to contribute to an individual's ability to 'feel intact' (Kitson, 1999).

In addition to this philosophy however, Kitson says that nursing also requires a set of practical skills that constitute the essential elements that make up patient-centred care. These include (Kitson, 1999):

1. Essential care – this includes putting the patient in the right environment to ensure optimal recovery. This is similar to Nightingale's emphasis on controlling the environment (Nightingale, 1860). It is perhaps the most important basic job of the nurse. It provides an answer to the key question: how can I ensure that the immediate environment is conducive to optimal care?

2. Technological care – this includes monitoring and observation skills, similar to Nightingale's 'sound and ready observation' (Nightingale, 1860) and Benner's 'reflective practice' of the expert nurse as the basis for sound

clinical judgement (Benner, 1984 and Benner et al 1999), that require an understanding of pathology, treatments, side-effects and potential hazards. This provides an answer to the question: how stable and predictable are the patient's physiological functions?

3. Psychosocial/emotional care / Information and Education – this includes interpersonal skills such as the ability to communicate, inform, educate patients, relatives and their carers. This provides an answer to the question: how stable and predictable are the patient's psychosocial and emotional states? It also provides an answer to the question: what does the patient need to know and learn about his or her condition or situation?

4. Continuity and coordination – this includes knowing how to provide a continuous, uninterrupted package of care, coordinated across geographic and service boundaries as well as between members of the healthcare team and the patient's own family (similar to what Nightingale (1860) referred to as 'taking charge'). This provides an answer to the question: how can I ensure that the patient experiences care that is uninterrupted and coordinated?

There are a number of common elements that run through the various definitions and interpretations of nursing that we have considered here. Together they go to make up what can be described as the essence of nursing. The core elements of this essence of nursing include the following:

1. **Person-centred care** – the individual experiences care in such a way as to feel that the nurse or midwife acts at all times in the interests of the person involved.
2. **Relationship based** – the experience of person-centred care is based on a relationship of empathy, of connection. The relationship is based on respect and consideration for the individual. It is animated by the values of equality, esteem, meaning, safety and trust.
3. **Holistic care** – the care provided by the nurse and midwife focuses on the totality of the person, physical, psychosocial, emotional. It is also sensitive

to the cultural circumstances of the individual. It is based on the values of respect for diversity.

4. **Education and promotion** – the care provided by the nurse or midwife is focused on promoting self reliance and independence in the individual. This includes providing them with the wherewithal to be able to become independent. It extends beyond the individual to their families and communities in order to ensure that support mechanisms are empowered to assist.
5. **Coordination** – nurses and midwives ensure that the individual has access to whatever is required to assist them to achieve self-reliance and independence. This includes coordinating the inputs of other professionals, making technology available as required and taking charge of environmental management issues that affect the well being of the individual.
6. **Knowledge based** – nurses and midwives invest in their own education and development, fully aware that clinical wisdom comes about as a result of experience combined with knowledge and understanding. Competence development is an essential ingredient in the accountability values that nurses and midwives build into their professional practice. Nurses and midwives see themselves as professionals who combine science and art in the interests of the individual under their care.

A number of nursing theorists have sought to articulate this essence of nursing in the form of 'nursing models'. These models have served as a framework for developing the theory and practice of nursing.

The Neuman model of nursing (Neuman, 1995) is a conceptual framework, a visual representation, for thinking about humans and nurses and their interactions. The model views the person as a layered, multidimensional whole that is in constant dynamic interaction with the environment. The layers represent various levels of defence protecting the core being. The two major components in the model are stress reactions and systemic feedback loops. Client reacts to stress with lines of defence and resistance (Neuman, 1995). Continuous feedback loops fine-tune the lines of defence and resistance so as

to achieve maximal level of stability. The client is in continuous and dynamic interaction with the environment. The exchanges between the environment and the client are reciprocal (each one is influenced by the other). The goal is to achieve optimal system stability and balance. Prevention is the main nursing intervention to achieve this balance. Primary, secondary, and tertiary prevention activities are used to attain, retain, and maintain system balance (George, 1996).

Patricia Benner applies the Dreyfus model of skill acquisition and applied it to nursing (Benner 1984). According to this model, nurses progress from being novices to experts principally though the knowledge they gain in the practice of nursing. In other words, the knowledge embodied in the practical world is important for the development of the nurse's skills and ability to care. Her area of concern was not how to do nursing but, rather, "how do nurses learn to do nursing?"

The Orem model of nursing was developed Dorothea Orem and is also known as the 'Self Care' Model of Nursing (Orem, 1985). It is particularly used in rehabilitation and primary care settings where the patient is encouraged to be as independent as possible. The Orem model is based upon the philosophy that all "patients wish to care for themselves". Self care requisites are groups of needs or requirements that Orem identified. They are classified as either: Universal self care requisites (those needs that all people have), developmental self care requisites (those needs that relate to development of the individual) and health deviation requisites (those needs that arise as a result of a patient's condition). When an individual is unable to meet their own Self care requisites, a Self Care Deficit occurs. It is the job of the Registered Nurse to determine these deficits, and define a support modality based on an analysis of the dependency level of the individual. The support modality will be designed to provide either total compensation or partial compensation, or as an educative and supportive intervention.

The Roper, Logan and Tierney (2000) model of nursing is a model of care based upon activities of living. The model is based loosely upon the activities of living

that are evolved from the work of Virginia Henderson (1966). Whereas Henderson identified 14 activities that people engage in, in order to live, Roper et al only use 12. The model breaks down what it means to live in the following categories:

- Maintaining a safe environment
- Communication
- Breathing
- Eating and drinking
- Elimination
- Washing and dressing
- Thermoregulation
- Mobilisation
- Working and playing
- Expressing sexuality
- Sleeping
- Death and dying

These should be considered within the dependence-independence continuum. The twelve activities of life are used in the initial assessment of a patient upon admission, and are reviewed as the patient's care plan evolves. To provide effective care, all of the patients needs (which are set out by investigating the patient's specific requirements relative to each activity) must be met as practicably as possible. The model also incorporates a life span continuum, where the individual passes from fully dependent at birth, to fully independent in the midlife, and returns to fully dependent in their old age/after death.

Taken together, these models of nursing combine to define the identity of nursing and midwifery. The translate the essence of nursing into frameworks for theory and practice. They also serve to distinguish clearly the model of nursing from the medical model.

The term ‘medical model’ was coined by the psychiatrist Ronald D. Laing in *The Politics of the Family and Other Essays* (Laing, 1971) for the set of procedures

in which all doctors are trained. This set includes complaint, history, examination, ancillary tests if needed, diagnosis, treatment, and prognosis with and without treatment. The medical model aims to find medical treatments for diagnosed symptoms and syndromes and treats the human body as a very complex mechanism. It drives research and theorizing about physical or psychological difficulties on a basis of causation and remediation. In this it is quite distinct from the holistic approach of the nursing model, based on care for the needs of the individual and the development of a relationship within which this care is provided.

As nursing and midwifery develop into areas of specialisation and advanced practice, it is important that the essence of nursing and midwifery is promoted and maintained. In Ireland, the National Council requires all those who wish to be recognised as CNS/CMS or ANP/AMP to demonstrate the contribution their work makes to nursing and midwifery practice. Thus, where the specialist or advanced practice is to be conducted in a particular area of practice (see Appendix 6 and 7 for a list of the areas of practice in place in October 2007), what is required is a demonstration of the nursing and midwifery contribution to the area of practice (National Council, 2007b; 2007c).

In developing areas of specialisation and advanced practice for nurses and midwives therefore, it is important that the medical model does not dominate. It is equally important that an economic model of organisational and structural change within the health services does not dominate. Thus for example, in developing the role of the nurse and midwife in the community, it is important that it is not driven solely by the need to achieve efficiencies or to substitute for the role of the GP or other healthcare professionals. The role of the nurse and midwife has an important part to play in adapting to the demands of efficiency and organisational change, but it must do so while remaining true to its own identity. It is only in this way that the profession of nursing can make its own specific contribution to the health of individuals and their families in society.

At times of change it is important to have a touchstone that ensures that core values and ideals are not lost in the maelstrom of evolution and change. This is

particularly important in nursing and midwifery in Ireland today, as it faces up to a future that holds many challenges of adaptation to new ways of working, new organisational structures, new relations with other professionals, new social and cultural changes. This thesis set out to provide a basis on which a strategy for the professional development of nursing in a changing health service could be formulated. This strategy needs to be imbued with the values and ideals that are at the heart of the professions – the essence of nursing. They form part of the identity of the professions and will be a central component of the strategy that emerges (chapter 8).

2.8 Conclusions

The following conclusions can be drawn from the analysis and discussion presented in this chapter:

1. The five points of entry to nursing and midwifery in Ireland will need to be reviewed in the light of the requirements of the Bologna agreement and of international best practice. The demands of the service for an integrated approach to service delivery would also suggest that a single point of entry based on interdisciplinary approaches to education and training of nurses and midwives would be desirable.

2. In developing the clinical career pathway for nurses and midwives particular attention needs to be given to maintaining the integrity of the profession. This entails recognising the prime importance of the generalist nurse and midwife engaging in direct provision of care to individuals in need. Development of specialties and advanced practice should be supportive of this key role and add value to the core function of nursing.

3. The nursing and midwifery profession has an important role to play in achieving efficiency and effectiveness gains in the reform of the health services. It is important in achieving this that the profession develops in line with its core values and identity.

4. The use of joint appointments between clinical and educational settings should be extended in order to emphasise the importance of the front line clinical role of the nurse in providing care.

5. Nurses and midwives should be encouraged to develop and lead services in both acute and primary care settings in a way that is responsive to the needs of patients and clients. Nursing management should provide the necessary leadership to make this possible, by empowering and encouraging individual nurses in this way.

6. Nurses and midwives should be facilitated and encouraged to engage in continuous professional development, promoting a culture of a lifelong commitment to learning. Consideration should be given to ways of demonstrating this commitment by providing evidence as a condition of continuing registration.

Many of the points raised in this chapter will emerge again in the next chapter, which deals with a number of key issues that need to be taken into account in the development of a comprehensive strategy for the development of nursing and midwifery. These include issues such as the development of strategies for the recruitment and retention of nurses and midwives, the empowerment of nurses and midwives and the development of leadership competencies within the professions.

Chapter 3 – Key Considerations for Strategic Planning for Nursing and Midwifery

3.1 Introduction

The previous chapter provided a description and analysis of the way in which nursing and midwifery in Ireland have developed in response to the social and policy context in which they operate. In this chapter it is intended to examine some of the factors that need to be taken into account in formulating a strategy for the future. It is not the intention of this chapter to formulate such a strategy. Such a task will require the presentation and analysis of the data that emerged from the primary research (to be presented in chapters 5, 6 and 7). The formulation of the strategy will be provided in chapter 8. In this chapter, it is intended to provide some framework considerations that will need to be taken into account in the strategy.

One of the principal challenges facing the professions of nursing and midwifery as we face an uncertain future is that of recruitment and retention. Ireland is not unique in this regard. Similar experiences exist in other countries. This chapter will look at the issues involved and consider strategic responses that have been developed in the United States and the United Kingdom.

The work of the Commission on Nursing (Government of Ireland, 1998) revealed that nursing and midwifery in Ireland suffered from problems of disempowerment and lack of leadership. These problems were seen by the Commission as important contributions to the lack of development of the professions in the past. In response to these problems, important policy initiatives have been put in place over the last 10 years to address them. This chapter will review these initiatives and examine their relevance to the future development of the professions.

Finally, the need for the formulation of a strategic response to the future developmental needs of the profession is not something unique in Ireland.

There are many examples of good practice in this area in other countries and international organisations. This chapter will examine some of these experiences with a view to learning the lessons that need to be borne in mind in formulating a strategy for the professional development of nursing and midwifery in Ireland (chapter 8).

3.2 Recruitment and Retention

Concerns about the recruitment and retention of nurses and midwives in Ireland over recent years have prompted a number of initiatives aimed at understanding the issues better and developing strategies to deal with them.

In 2002, a detailed study of the Nursing and Midwifery Resource was commissioned by the DoHC entitled *The Nursing and Midwifery Resource: Final Report of the Steering Group – Towards Workforce Planning* (DoHC, 2002b) (known as *Towards Workforce Planning*). This was the first large scale piece of work on this subject in Ireland and it identified for the first time a comprehensive approach to workforce planning for nursing and midwifery. One of the major achievements of the report was the establishment of the *National Nursing and Midwifery Human Resource Minimum Dataset*. The report described this as a critical instrument for the successful implementation of workforce planning and recommended that it be adopted and used by all organisations employing nurses and midwives. In order for the *Minimum Dataset* to be useful in providing the information necessary for forecasting, the report stated that it was essential that information on turnover rates and vacant posts should continue to be collected and the underlying reasons for leaving employment should be analysed. The report recommended that the NMPDUs should collect and collate this data on a regional basis and submit it for national collation and analysis. There is evidence that the NMPDUs are fulfilling their role in this regard, e.g. the NMPDU responsible for the HSE nursing and midwifery areas of Dublin, Kildare and Wicklow produced a report entitled *Nursing and Midwifery Turnover Data Report for Year Ending 2005* (HSE, 2007f). There are workforce planners based in each of the NMPDU Units who

are responsible for the collation of regional data and the preparation of reports. However, there is a need to address the question of continued national collation and analysis as there is no evidence that this is being done at the moment.

The Steering Group responsible for the preparation of *Towards Workforce Planning* (DoHC, 2002b) commissioned an additional study entitled *National Study of Turnover in Nursing and Midwifery* (DoHC, 2002c). The report indicated that turnover in nursing and midwifery varied enormously throughout the health system. Across hospital bands and services the report indicated that the overall turnover rate had decreased from 17% in 1999 to 15% in 2000 and 14% in 2001. While turnover rates had not reached levels experienced in other countries, the report identified it as a real issue requiring focused attention. The report also identified a number of factors that affect turnover. These factors included issues such as age, work experience, tenure, kinship responsibilities, education, promotional opportunity, pay, distributive justice, work environment, alternative employment opportunity / job market, job commitment, job satisfaction and behavioural intention.

In 1999 *The Nursing Recruitment & Retention Group Report* (Dublin Academic Teaching Hospitals (DATHS, 2000) published the outcome of an analysis of vacancies in the hospitals that formed part of the group. The report recommended a number of initiatives that were intended to contribute to an improvement in the attractiveness of nursing and midwifery for recruitment purposes and an improvement in the working conditions of those already in the profession. These initiatives were in the areas of Continuing Professional Development (CPD), induction programmes, improvement of contracts, introduction of more flexibility in working hours, return to work initiatives, provision of crèches and increased participation in work committees.

In the United States, the American Academy of Nursing reported on hospitals that were able to recruit and retain highly qualified nurses in a competitive market. These were known as the Magnet hospitals. Research showed that Magnet hospitals that met the criteria for accreditation as Magnet hospitals by the American Nurses Credentialing Center have better outcomes than non

magnet hospitals (Aiken et al, 2000). The principal feature of Magnet hospitals is a focus on creating job satisfaction opportunities for nurses by creating professional nursing practice opportunities (Aiken, 1995). Magnet hospitals embodied a set of organisational attributes that nurses find desirable and that create a work environment conducive to the provision of nursing care. This was seen as having a significant impact on recruitment and retention of nurses.

Condon (2004) identified the 14 forces of magnetism. These included: quality of nursing leadership, organisation structure, management style, personnel policies, professional models of care, quality of care, quality improvement, consultation and resources, autonomy, community outreach, nurses as teachers, image of nursing, interdisciplinary relationships and professional development.

In response to the challenges of high turnover and vacancy rates and over reliance on international recruitment in London, the National Health Service (NHS) commissioned a report entitled *Grow Your Own – Creating the Conditions for Sustainable Workforce Development* (King's Fund, 2006). The report described a range of *Grow Your Own Strategies*, the key characteristics of which are: look to local labour markets as a key source of workforce supply, and encourage organisations to use the skills and talents of the existing unregistered or 'not formally qualified' workforce more effectively. The report stated that developing and extending staff roles, especially to meet new service requirements and expectations, can achieve a more sustainable approach to workforce development and utilisation. The report is also seen as underpinning the reforms within the health services by encouraging a change in culture and practice. This entails a shift away from a workforce that is largely defined by professional qualifications and distinct occupational groups to one that is defined by skills and competencies, and is centred on the patient.

Some moves in this direction have also occurred in Ireland with the renewed emphasis on the important role to be played by health care assistants in the health service. *The Report of the Working Group on the Effective Utilisation of Professional Skills of Nurses and Midwives* (DoHC, 2001d) examined in detail

the recommendation of the Commission on Nursing (Government of Ireland, 1998) that health service providers and nursing organisation should examine opportunities for increased use of care assistants and other non-nursing staff. The report recommended the introduction of the grade of Health Care Assistant / Maternity Health Care Assistant as a member of the healthcare team to support the nursing and midwifery function. It was intended that the introduction of support workers should allow nurses and midwives to spend more time engaged in direct patient care. The report also recommended that appropriate provisions be made for the education and training of these support workers.

As a result of the recommendations of the report (DoHC, 2001d), a national pilot programme for the education of Health Care Assistants was introduced in 2001. This consisted of a level 2 training programme, developed specifically for health care assistants by the Further Education and Training Awards Council (FETAC) and the National Council for Vocational Awards (NCVA) in conjunction with key stakeholders. On conclusion of the course, participants were awarded a level 2 Healthcare Support Certificate. In 2002, an evaluation of the national pilot programme for the education of healthcare assistants was carried out (DoHC, 2003h). The main recommendation of this report was that due to the success of the Healthcare Support Certificate, it should be delivered again and should be developed and expanded to train all healthcare assistants across Ireland.

Additional initiatives in the training of support staff include the SKILL[5] Project (www.skillproject.ie Accessed 14th October 2007), which was set up in partnership between the trades unions and the HSE to provide education, training and development opportunities to staff working in support grades within the Irish health and personal social services. The SKILL Project provides education, training and development initiatives to around 28,500 support staff and support service managers in the health services including healthcare assistants, porters, catering assistants, household staff, semi-skilled persons / crafts-persons mates, maintenance persons, home supports workers,

[5] SKILL is an acronym for Securing Knowledge Intra Lifelong Learning.

community carers, family support workers, general assistants, therapy assistants, speech and language assistants, laboratory aides and laundry staff.

In May 2007 the HSE and the SKILL Project commissioned a national review of the role of the healthcare assistant in Ireland. The purpose of the review is to establish the role and function of the Healthcare Assistant in the HSE on completion of the Healthcare Support Programme (FETAC Level 5). At the time of writing (October 2007) the report is in preparation.

In August 2005, as part of a series of monitoring reviews on the supply and demand of skills in different economic sectors in Ireland, the Skills and Labour Market Research Unit (SLMRU) in FÁS published *Healthcare Skills Monitoring Report* (FÁS, 2005). The primary aim of the report was to identify any current and future shortages of healthcare skills and to suggest approaches to tackling any gaps that may exist between supply and demand. The report identified three groups of occupations, each of which displayed different supply demand characteristics and required therefore different approaches.

Group 1 consisted of occupations for which the analysis shows that an increase in training places, as well as a continued focus on appropriate human resource strategies, is the most appropriate response to the gap between projected domestic supply and demand. The report (FÁS, 2005) stated that these occupations have long term supply shortfalls, which cannot entirely be filled by other means. Registered Children's Nurses were included in this group. The report stated also that increasing training places for these occupations in isolation would not be the best policy. Other methods of eliminating shortages included adjusting the skills mix between the occupations, improving retention rates, promoting immigration and increasing productivity. The report concluded that in the short to medium term, immigration would continue to play a key role in filling positions in these occupations. Once graduates from new or expanded courses begin to enter the workforce, the need for immigrant workers in these occupations would ease.

Group 2 consisted of occupations for which the analysis has shown a possible shortfall of domestic supply in the future. For these occupations, increasing domestic supply by increasing training places may be an appropriate response in the medium term depending on how the demand situation develops. However, other methods of reducing shortages should be introduced and evaluated before additional training places are considered. The nursing occupations in this group include Registered General Nurses and Health Care Assistants. The Report (FÁS, 2005) recommends a continuance of the current policies and an assessment of their impact before increasing training places. Current policies include adjusting the skills mix between occupations, improving retention rates, promoting immigration and increasing productivity.

Group 3 consists of occupations for which the analysis shows no major gap between domestic supply and demand. The nursing occupations in this group include Registered Intellectual Disability Nurses (RNID), Registered Public Health Nurses (PHN), Registered Psychiatric Nurses (RPN) and Registered Midwives (RM). For these occupations, the report (FÁS, 2005) forecasts that there will be no immediate shortages of supply (up to the year 2014) but that the situation should be closely monitored.

In order to address the problems of recruitment and retention of nurses and midwives therefore, it is necessary to develop strategies that are based accurate statistics that monitor trends and provide a solid basis for forecasting supply and demand patterns in critical areas. It is also necessary to address workplace issues that determine the attractiveness of the work of a nurse for potential recruits and for existing professional staff.

3.3 Leadership and Empowerment in Nursing and Midwifery

3.3.1 The Issues

Among the issues identified during the consultative process engaged in by the Commission on Nursing, the following related directly to management and leadership issues within the profession (Government of Ireland, 1998):

- The need for greater internal communication within organisations
- A perception that nurses / midwives and nursing / midwifery were not sufficiently involved in strategic planning or in policy development and strategy development
- The perception that there was a lack of partnership and consultation between general management and nursing / midwifery management and between nursing / midwifery management and nurses / midwives in the setting and attaining of corporate goals
- A concern that nursing and midwifery management was preoccupied with hierarchies and the detailed control of nurses and midwives rather than the management of the nursing and midwifery function
- The need to examine the recruitment, selection and training of nurse / midwife managers in order to ensure that the profession had an effective cohort of leaders capable of responding to changing service needs
- The need for a greater devolution of authority within the nursing and midwifery management structure.

These issues were also identified in a supplementary report prepared for the Commission on Nursing entitled *Management in the Health Services – The Role of the Nurse. A Report Prepared for the Commission on Nursing* (Flynn, 1998).

In response to these issues, the Commission made specific recommendations regarding internal communications within health service organisations (Government of Ireland, 1998, 7.5 to 7.12), professional and personal career planning (7.13 to 7.14) and the involvement of nurses and midwives in the strategic planning of the nursing and midwifery service.

To support these recommendations, the Commission recommended the creation of certain institutional arrangements to copper-fasten and give

institutional structure to the general recommendations. These included the creation of a new clinical career pathway and the establishment of the National Council (Government of Ireland, 1998), the strengthening of the role of the Chief Nursing Officer at the DoHC (Government of Ireland, 1998, 7.16) and the creation of the NMPDUs (Government of Ireland, 1998, 7.17). All of these recommendations were intended to provide for a more meaningful involvement of nurses and midwives in strategic planning and to encourage the emergence of nurse leaders capable of influencing the direction of policy and management decisions.

The Commission also made specific recommendations regarding the roles of nurses and midwives in the management of nursing and midwifery (Government of Ireland, 1998, 7.19 to 7.57). These recommendations refer to senior nursing and midwifery management, who were now to be referred to as directors of nursing and midwifery (Government of Ireland, 1998, 7.19 to 7.23), middle nursing and midwifery management (Government of Ireland, 1998, 7.24 to 7.30) and first line nursing and midwifery management (7.31 to 7.45). They also refer to the involvement of nurses and midwives in general management (7.51). In all of the above, leadership in both general management and clinical settings is emphasised as a central requirement in the competence sets required of these managers.

It is clear, therefore, that the Commission on Nursing held the view that it is a key requirement of the management of an effective health service that nurses and midwives should be enabled, and empowered to contribute to their full potential in the strategic development of the services. It is also clear that there is an onus on nursing management to provide the leadership necessary to ensure that the profession achieves its full potential in this regard.

In addition to establishing the institutional structures recommended by the Commission and referred to above, the DoHC also established in 2000 a high level steering group on the empowerment of nurses and midwives. The steering group identified four main areas requiring attention: management development, service planing, communication and empowerment (DoHC, 2003g).

3.3.2 Empowerment

In September 2003, the DoHC issued the final report of the steering group on the empowerment of nurses and midwives entitled *Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland – Final Report* (DoHC, 2003g). The principal findings and recommendations for action contained in the report are summarised in Table 3.3:

Table 3.3 – Empowerment of Nurses and Midwives in Ireland (DoHC, 2003g)

Findings of the Research	**Recommendations for Action**
Organisational Development	
1) Nurses are invisible in organisations – they are not involved in organisational decision-making and they lack information about their organisations	• Review organisational communication strategies in order to tackle the issue of invisibility • Ensure balance between medical, nursing/midwifery and administration input to strategic planning and decision making.
2) Nurses perceive a lack of recognition and reward for innovation in practice.	• Establish and implement best practice in areas of enabling, recognising and rewarding effective innovation in clinical practice
3) Staff shortages are a barrier to the provision of quality nursing care and to enabling access to continuing education	• Implement effective workforce planning to meet existing and future HR and service needs • Link performance feedback and objective setting to objectives and strategic needs of organisation • Implement action plan recommended by Nursing and Midwifery Resource Group (DoHC, 2002b).
Management Development	
4) Management style is an important influence on empowerment	• Adopt a systematic approach to the identification of nursing and administrative training and development needs • Deliver appropriate training and development programmes to meet those needs
5) Nursing management is influential in enabling clinical staff to function in an empowered manner	• Provide ongoing appraisal and support to nurse managers across the health service.

Findings of the Research	Recommendations for Action
	• Make wider use of the Nurse Management Competencies Framework (OHM, 2003c)
Practice Development	
6) Nurse/midwife led practice is an empowering and enabling innovation	• Build on existing initiatives to further enable innovation in nurse/midwife led services and extend these practice models across all nursing and midwifery divisions and areas of practice • Provide appropriate support for education, research and pilot projects. • Nurses and midwives must themselves seize the opportunities offered by these developments.
7) Personal and professional confidence is central to empowerment	• Explore, identify and implement interventions aimed at fostering the professional and personal confidence and self-esteem of nurses and midwives
8) Difficulties accessing resources needed for client needs, particularly in the area of intellectual disabilities	• Review and develop systems to ensure appropriate access to the resources required to meet client needs, particularly in the area of intellectual disabilities
9) Difficulties in meeting increased public expectations and demand fro health services created by publications into which nurses and midwives have had no input	• Provide nurses and midwives with appropriate preparation in order to enable them to deal effectively with increased public expectation and demand • Ensure clinical nursing/midwifery input into the development of health service information material aimed at the general public, especially those publications dealing with health service pro vision and consumer rights
Education	
10) Adequate education and continuing education is critical to empowerment. Barriers to accessing education include staff shortages, with nurses and midwives having to find their own replacement cover, geographical distances and lack of resources for staff development and training	• Safeguard access to appropriate continuing education by identifying and meeting resource (both human and financial) and geographical requirements • Provide for e-learning opportunities, aimed at increased effectiveness and optimising use of resources • Provide a greater emphasis on the use of informal, on the job training, recognising that much of nurses and midwives learning takes place in the clinical setting

Findings of the Research	Recommendations for Action
	• Greater use of personal development plans • Explore other mechanisms to deliver training: coaching, mentoring (internal and external), action learning and clinical supervision • Centres for nurse education potentially have a primary role to play in promoting the professional development of all staff. Their evolving role should assist in meeting needs identified in this report
11) Concerns and uncertainties about scope of practice, accountability and legal issues	• Provide continuing and accessible education about the scope of practice and practitioner accountability within the evolving legal framework in which nursing operates

Finding 5 of the study (Table 3.3) refers to the report produced by the Office for Health Management (OHM) (OHM, 2000), on nursing management competencies. This study identified a number of key competencies required for each of the different levels of nursing management. At the top level, key competencies required include strategic and system thinking, establishing policy, systems and structures, leading on vision and values, stepping up to the corporate agenda and adopting a development approach to staff. At middle management level, key competencies required include proactive approach to planning, effective coordination of resources, an empowering / enabling leadership style, setting and monitoring performance standards and negotiation skills. At front line level, key competencies required include planning and organisation of activities and resources, building and leading the team and leading on clinical practice and service quality.

The report also identified a number of generic competencies that should be present throughout the nursing and midwifery profession. These include promoting evidence-based decision-making, building and maintaining relationships, communication and influencing relationships, service initiation and innovation, resilience and composure, integrity and ethical stance, sustained personal commitment and practitioner competence and professional credibility.

These competencies provide a description of what an empowered, confident, professional nurse / midwife manager will look like and how she/he will behave. The empowerment study (DoHC, 2003g) on the other hand describes an institutional setting that militates against empowerment. Nurses and midwives 'feel invisible' (Table 3.3, finding 1), they are not communicated with and they feel a lack of recognition for their innovation and practice.

Work environments that provide access to information, resources, support, and the opportunity to learn and develop are empowering (Kanter, 1993). In such an environment, employees are encouraged by management to act on their expertise and judgement and, accordingly, they are able to accomplish their work successfully. As a consequence of empowerment, employees are more committed to the organisation, have higher levels of trust in management, are more accountable for their work and are less likely to experience job strain. It may be inferred from the empowerment study (DoHC, 2003g) that this kind of organisational environment is not the norm for nursing and midwifery in Ireland.

Laschinger et al (2001a) looked at the Impact of structural and psychological empowerment on job strain in nursing. The study was based on an expanded model of Kanter (Kanter, 1993). Laschinger points out that organisational restructuring in health care settings over the last decade has had profound effects on the way healthcare is delivered. Nurses in particular have been hit hard by restructuring. Campbell (1987) notes that cost-driven changes in management methods systematically devalue nurses' knowledge and displace their professional judgement. Campbell also claims that nurses have been required to absorb a disproportionate amount of the cost containment burden and that rather than increase productivity, these changes have resulted in patient dissatisfaction and increased work stress among nurses. Given that restructuring may endanger patient care, it is critical to find ways to help nurses to do their work effectively.

In one landmark study, Aiken et al (1994) demonstrated that hospitals with strong supportive nursing work environments had significantly lower mortality

rates than those that did not. These findings are consistent with Kanter's theory of organisational empowerment. They are also consistent with the findings of the empowerment study (DoHC, 2003g) where it identified staff shortages (see Table 3.3, finding 3) and difficulties in accessing resources (Table 3.3, finding 8) as consequences of restructuring that disempowered nurses and midwives. The inability to access basic financial resources for practice, through a system of budget devolution and accountability, militates against any possibility of developing an empowered nursing and midwifery workforce.

The work of Laschinger et al (1999) concluded that leader-empowering behaviours significantly influenced employees' perceptions of formal and informal power and access to empowerment structures (information, support, resources and opportunity). Higher perceived access to empowerment structures predicted lower levels of job tension and increased work effectiveness. They concluded that this empowered work force requires new models of leadership and a 'letting-go' of the control formally held by managers. In times of great organisational change, leaders need to develop skills and attitudes that facilitate individual and organisational transitions necessary for success in redesigned empowering work settings.

A later study (Laschinger et al, 2001b) links empowerment to restructuring and re-engineering issues in organisations. They identify the need to move away from command and control to coordination, integration and facilitation. Managers have to seek ways of regaining the trust of employees as restructured nurses' work environments recover from the impacts of successive downsizing and changes.

Attempts have been made to measure staff empowerment within health service organisations (Irvine et al, 1999)**.** A survey was conducted of 457 hospital staff, including professional, support and administrative staff. The factor analysis indicated three dimensions of empowerment – behavioural, verbal and outcome empowerment. These three dimensions were positively related to leadership behaviour that encouraged self-leadership and negatively related to directive leadership. The three dimensions discriminated between the

empowerment level of managers compared to that of non-management staff. Empowerment predicted organisational citizenship behaviour and job behaviours related to quality improvement. Klakovich (1995) looked at scales of empowerment through the development and psychometric evaluation of the *Reciprocal Empowerment Scale*, which was the scale used in the Irish empowerment study (DoHC, 2003g).

In addition to the importance of building personal and professional confidence, the empowerment study (DoHC, 2003g) addresses the question of professional development with reference to nurse-led services (Table 3.3, finding 6), the importance of access to adequate continuing education (Table 3.3, finding 10), and the importance of support in addressing scope of practice issues (Table 3.3, finding 11). This raises the question of empowerment in the clinical environment. The work of the National Council, in developing a clinical career pathway for nurses and midwives and providing a framework within which progress can be made along this clinical career pathway, provides the basis for the development of empowered clinical professionals. This is supported at regional level through the work of the NMPDUs. The empowerment study, however, (DoHC, 2003g) fails to make any reference to the work of the NMPDUs or to the work of the National Council. These institutions were set up as part of the institutional framework recommended by the Commission on Nursing and when the empowerment study was being completed, they were already operational, albeit they were at an early stage in their development.

The National Council was responsible for the development of a clinical career pathway from generalist to specialist to advanced practice for nurses and midwives in line with the recommendation of the Commission on Nursing (Government of Ireland, 1998). This was underpinned by the publication in 2001 of *Clinical Nurse / Midwife Specialists Intermediate Pathway* (National Council, 2001a) and *Framework for the Establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts* (National Council, 2001b). In 2002, the National Council published *Guidelines on the Development of Courses Preparing Nurses and Midwives as Clinical Nurse / Midwife Specialists and Advanced Nurse / Midwife Practitioners* (National Council, 2002). This was

followed up in 2004 with the evaluation of the role of CNS/CMS, the results of which were published in *An Evaluation of the Effectiveness of the Role of Clinical Nurse/Midwife Specialist in Ireland* (National Council, 2004c). The results of the evaluation provided the basis for a reassessment of the framework documents. This was followed by revised editions of the Frameworks for CNS / CMS and ANP / AMP Posts (National Council, 2004a & 2004b) In 2005, a preliminary evaluation of the role of the ANP) was carried out. This was published as *A Preliminary Evaluation of the role of the Advanced Nurse Practitioner* (National Council, 2005e).[6]

The staff nurse, staff midwife, CNS / CMS and the ANP / AMP have a crucial roles in providing clinical leadership to nurses and midwives in the clinical setting. They also have a role in providing mentoring, education, training and guidance to nurses and midwives in both the clinical and formal educational settings. They are also instrumental in initiating and leading clinical research in nursing and midwifery. Their role therefore goes a long way towards addressing the issues raised in the empowerment study (DoHC, 2003g) under the headings of practice development and education (Table 3.3). The creation of these posts, in line with the provisions of the Framework documents, involve consultation and cooperation between local nursing and midwifery management and the NMPDU, resulting in the formulation of recommendations for inclusions of these posts in the service plan. In this way, nursing and midwifery is becoming more proactive in the shaping of health services through service planning.

The National Council was also responsible for the creation of new opportunities for continuing education for nurses and midwives (Government of Ireland, 1998). This pre-empts the findings of the empowerment study (DoHC, 2003g) and in particular finding 10 (Table 3.3). As an initial step in this process, the National Council published *Criteria and Processes for the Allocation of Additional Funding for Continuing Education by the National Council* (National Council, 2001c) and an updated version in 2007 (National Council, 2007e). This publication provided a step by step guide to the procedures to be followed by

[6] See detailed discussion of this in chapter 2 (2.3.2)

directors of nursing and midwifery in cooperation with the NMPDUs to access funding for continuing education programmes. As a form of additional guidance, in 2003 the National Council published *Guidelines for Health Service Providers for the Selection of Nurses and Midwives who might apply for financial support in seeking opportunities to pursue further education* (National Council, 2003c). The website of the National Council also provides information to nurses and midwives on educational and development opportunities provided by third level educational establishments. The National Council has funded continuing educational opportunities for nurses and midwives, including courses, workshops, seminars, conferences and other events.[7]

The empowerment study (DoHC, 2003g) also calls for more attention to be given to personal development plans for nurses and midwives (Table 3.3, finding 10). In this regard it should be noted that the National Council has published *Guidelines for Portfolio Development for Nurses and Midwives* (National Council, 2003b and 2006d), which provide a structured framework for nurses and midwives to build their own professional development profile.

In addition to these activities and publications, the National Council has carried out a number of detailed analyses of professional development issues for nurses and midwives. These include *Agenda for the Future Professional Development of Nursing and Midwifery* (National Council, 2003a); *Report on the Continuing Professional Development of Staff Nurses and Midwives* (National Council, 2004d); *An Evaluation of the extent and nature of nurse-led / midwife led services in Ireland* (National Council, 2005f); *Clinical Nurse Specialists and Advanced Nurse Practitioner Roles in Emergency Departments: Position Paper* (National Council, 2005b); *Clinical Nurse Specialists and Advanced Nurse Practitioner Roles in Intellectual Disability Nursing: Position Paper 2* (National Council, 2006b) and *Clinical Nurse Specialists and Advanced Nurse Practitioner Roles in Older Persons Nursing: Position Paper 3* (National Council, 2007d). In addition a report entitled *Service*

[7] See more detailed discussion of these points in chapter 2 (2.5)

Needs Analysis for Clinical Nurse / Midwife Specialists and Advanced Nurse / Midwife Practitioners was also produced in 2005 (National Council, 2005c).[8]

The empowerment study (DoHC, 2003g) provides us with an in-depth analysis of nursing and midwifery in Ireland. It paints a picture of a professional cohort within the health services that views itself as disempowered. The literature review confirms that there is a need to create structures and practices within organisations that ensure the free flow of information and facilitate involvement of individual managers in decision making as a basis for the creation of a sense of empowerment. The literature also highlights the negative impact that organisational restructuring can have on nursing and midwifery, which is of particular relevance in Ireland as the Health Services Reform Programme continues to be implemented. Much progress has been made in Ireland through the work of the National Council and the NMPDUs, in close cooperation with the directors of nursing and midwifery, to create the conditions necessary for the emergence of an empowered profession of nursing and midwifery. Much of this progress has been made in the period since the publication of the empowerment study (DoHC, 2003g) over the years 2001 to the present date. The research to be conducted as part of this thesis will seek to throw light on how far nursing and midwifery has come and how much remains to be done as a basis for the formulation of a strategy for the development of nursing and midwifery in a changed health service. What is clear, however, at this stage is that if nurses and midwives are to become more empowered within the health services, there will be a need for leadership from within the profession itself.

3.3.3 Leadership

There is a close link between empowerment and leadership. Kanter (1993) in the classic book *Men and Women of the Corporation* maintains that work environments that provide access to information, resources, support, and the opportunity to learn and develop are empowering. In such an environment, employees are encouraged by management to act on their expertise and

[8] See additional discussion of these issues in chapter 2 (2.3.2)

judgement and, accordingly, they are able to accomplish their work successfully. As a consequence of empowerment, employees are more committed to the organisation, have higher levels of trust in management, are more accountable for their work and are less likely to experience job strain. Empowerment therefore must be seen as a condition that is necessary for the emergence of leaders within organisations.

A study of nurse leaders' perceptions of what comprises successful leadership in today's acute inpatient environment, set out to gain understanding of nurse leaders' perceptions of both the value of their roles in today's health care settings and their beliefs about how power and gender interface with role worth (Upenieks, 2003). The study refers copiously to Kanter's Structural Theory of Organisational Behaviour (1993). Sixteen nurse leaders were recruited for the study in both magnet (7) and non-magnet hospitals (9). Interviews lasted from 60 to 90 minutes and were taped. The results of the deductive analysis supported Kanter's theory – 83% of nurse leaders confirmed that access to power, opportunity, information and resources created an empowered environment, producing a climate that fostered leadership success and enhanced levels of job satisfaction among nurses.

In the Irish context, Carney (2004) looked at middle manager involvement in strategy development in not-for-profit organisations and in particular the director of nursing's perspective. She looks at how organisational structure impacts on the role. The study highlighted the problems experienced by directors of nursing within organisations – exclusion from strategic decision making resulted in poor communication flow and lack of access to senior managers, resulting in a sense of isolation, of being controlled and of decisions being made that were of major concern to nursing and the organisation without any involvement with the director of nursing. Directors of nursing are seen as occupying a middle management role. These findings echo the results of the earlier empowerment study (DoHC, 2003g). Carney highlights the critical role directors of nursing should have in nursing management and the wider health service context. Nursing and nurse management have enormous potential to influence health care strategy and health care delivery. However, in order to do

this, it will be necessary to work in multidisciplinary cooperation and alliance based models of care delivery. Nurses will have to demonstrate strategy development and planning and delivery of effective evidence based and efficient nursing care and be seen to benefit the health service as a whole. This involves a fundamental reappraisal of the role of the director of nursing including shedding of non strategic elements of the role and the empowering of clinical nurse managers. It involves therefore the creation of an organisational environment such as that described by Kanter (1993) in which leadership emerges as a result of empowerment.

In the context of the NHS in the United Kingdom, Fradd (2004) asked what is needed to lead in a political environment such as NHS. The following leadership competencies were identified –

1. Political astuteness
2. Compassion
3. Ability to work independently
4. Effective collaborator
5. Ability to develop high trust relationships
6. Self confidence tempered with humility
7. Respect for the process of change as well as the content
8. Ability to work across business functions and units

Fradd concluded that in the case of directors of nursing the lack of an appropriate balance between the strategic role, leading nursing and being responsible for operational matters has not infrequently left them isolated and the target of blame.

Sofarelli and Brown (1998) looked at the need for nursing leadership in uncertain times (e.g. during periods of significant organisational and structural reform, such as is occurring as part of the health services reform programme in Ireland) and suggested that transformational leadership was the model that would assist nursing to develop into an empowered profession with the potential to be a dominant voice in reshaping the healthcare system of the future.

The question of transformation leadership and the nurse executive was examined by Dunham and Klafehn (1990). Because of the inherent uncertainty of healthcare, leadership requires individuals who are capable of making decisions, with a committed, long-term vision of what can be accomplished, capable of identifying common values with staff needs. Leaders need to inspire others with a vision of what can be accomplished. Empowering staff members to do their best based on a shared values system is at the heart of transformational leadership. The nurse executive and other nursing administrators need to develop transformational leadership skills at staff nurse level in a manner that will ensure that individual staff nurses manage patient care with a vision of what can be accomplished when delivering care.

A study entitled *Leadership in Nursing: Where do we go from here? The Ward Sisters Challenge for the Future* (Carney, 1999), concluded that by adopting a transformational leadership style, nurse managers / ward sisters can significantly enhance staff morale and patient care delivery. Transformational leadership seeks to empower nurses at all levels. Carney concluded that transformational leadership is best suited to the elimination of the inappropriate use of power within the organisation and that the Ward Sister can help to empower staff through transformational leadership**.**

A research study conducted by Antrobus and Kitson (1999) concluded that leadership in nursing in the UK to date has been predominantly concerned with professional issues and as a result has focused on developing nurses and nursing. This study examined broader socio-political factors impacting upon nursing leadership. Nursing and nurse leadership is shaped by the impacts of politics and policy. The study identified a repertoire of skills that nurse leaders require to influence the political factors –

1. A powerful influential operator
2. A strategic thinker – creating meaning and facilitating learning
3. A developer of nursing knowledge
4. A reflexive thinker

5. A process consultant

Nurse leaders need to provide both practice and policy leadership.

Scoble and Russell (2003), in examining the document *Vision 2020* looked at the profile of the future nurse leader. The study consisted of a survey of participants at an Institute for Nursing Healthcare Leadership (INHL) Conference in June 2001. There were 125 participants at the conference and the survey is based on 43 respondents. The results of the survey centred on four key areas. First, with regard to the ideal educational preparation for future nurse leaders, most of the respondents emphasised the importance of postgraduate educational levels in Nursing and in Business Administration (MSN, PhD and MBAs). With regard to the curriculum content for future nurse managers, the vast majority of respondents emphasised the broad business disciplines, including business administration, financial management, human resources, information systems and economics. When asked about desirable professional and managerial experiences for future nurse managers, again the emphasis was on business skills such as budgeting and finance, project management and human resource management. Finally, when asked about the key competencies for successful nurse managers in 2020, respondents emphasised the importance of leadership behaviours and skills, financial and budgeting, business acumen, management skills and communication skills. They also emphasised the importance of collaborative and team skills allied to clinical skills and knowledge.

A study conducted much earlier by Hennessy et al (1993) examined the corporate role of the nursing director. Findings of a study initiated by South West Thames Regional Health Authority (SWTRHA, 1992) during 1991 aimed at identifying the specific set of competencies that incumbent and designate trust nursing directors and / or their future successors, will need to develop in order to fulfil their future roles successfully. The study identified a three stage evolutionary role for the trust nursing director.

Stage one involved leading the transformation in nursing by using personal networks, by building constructive relationships, by articulating patient care and motivating people, by championing the human consequences of change, planning and managing change and delegating decision-making, and by planning self-development and using basic concepts of business management.

Stage two involved charting the way ahead by the use of business planning, linking people capability with strategy, initiating projects, monitoring progress, aligning organisations and processes with strategy, providing strategic leadership, interpreting environmental and competitive trends, setting goals and milestones, allocating resources and developing successors.

Stage three involved assuming full executive status, including managing capital projects, directing a health gain focused organisation, contributing to trust evolution, managing external relationships and using high level of business management expertise.

A study aimed at identifying and developing future trust nursing directors concluded that the NHS reforms are having fundamental impact on the culture, structure and financing of the NHS and the way in which patients receive care (Hennessy and Gilligan, 1994). The challenges this presents for the future of nursing practice, management and leadership are profound. For example, as a result of this study, the SWTRHA developed a 'career development and planning system' (CDPS) in anticipation of NHS reforms for senior managers in 1991, 1992 and 1993. The CDPS was based on an understanding of the competencies nursing directors are expected to have at the time of their appointment or be capable of developing shortly thereafter. A total of 11 key competencies were identified. A list of these competencies is provided in Appendix 14.

The need for nurses to become more active in policy development and the wider world of politics at organisational and national level is well documented (Crossan, 2003). Nursing has been described as operating within a political vacuum with little or no input into the development of health policy apart from

grassroots implementation (Antrobus and Kitson, 1999). Research has found the profession to be internally focused rather than looking at nurse leadership in the broader socio-politic world in which it takes place (i.e. at a strategic level) and how it is influenced by it.

In a survey of Irish student midwives Begley (2002), concluded that a hierarchical system was in operation in the majority of maternity hospitals included in this study; this has been noted in other studies also (West et al 1999). The origins of this hierarchical framework are, it was suggested, to be found in the continuation of midwifery from the male medical-dominated profession of nursing, to the existence of the industrial/economic model of maternity care, or to the impact of the medicalisation of childbirth.

McKenna et al (2004), conducted a study entitled *Nurse Leadership within Primary Care: The Perceptions of community Nurses, GPs, Policy Makers and Members of the Public*. Based on Northern Ireland Nursing Strategy document entitled *Valuing Diversity… A Way Forward* (Department of Health, Social Services and Public Safety (DHSSPS, 1998), the study sets out key messages, challenges and opportunities for leaders in nursing and emphasises the positive effect this would have on improved quality of service. It asserted that in order to grasp these opportunities nursing had to invest in the development of leaders.

The study accepts the principles of the UK's King's Fund Leadership Programme (King's Fund, 1996) as characteristics which leaders within nursing must aspire to have. Leaders must be –

1. A visionary: able to create, articulate and encourage of a vision for nursing
2. A communicator: able to communicate and effectively market needs, demands and views of nurses and those they serve
3. A strategist: able to formulate and implement strategy
4. An environmentalist: able to adapt the organisation to a changing environment

5. A political operator: able to work within local, national and international priorities and to use political awareness
6. A confident leader: able to contribute fully to the development of nursing within a previous ability in empowering staff
7. A confident professional: able to be self aware and to recognise and maximise personal impact.

The study used the 'Delphi Technique' for research, focus groups and semi-structured interviews and involved 60 participants from Ireland and Northern Ireland. Three themes emerged from the focus groups for GPs:

1. GPs have a role as a leader of the multi-professional community / primary care team
2. The perception that whoever is the budget holder is the leader
3. Unlike most other health professionals, GPs' work represents a business.

The themes that emerged from the focus groups for community nurses included:

1. The GP is the leader of the primary care team
2. Nurses who become leaders generally leave practice
3. A leader has natural leadership qualities
4. There should be fast tracking of young nurses with recognised leadership potential
5. Nurses are often encouraged to be managers rather than leaders.

In reviewing the literature on leadership, there appears to be a number of common themes that emerge. In fact it is possible to identify three critical levels on which leaders operate and which demonstrate three families of competencies and skills.

First, leaders are clearly individuals who have a clear set of **values,** which they are capable of converting into a **vision** of what they want and can **articulate** this vision clearly. It is this combination of values, vision and ability to articulate

that sets leaders apart from others. This includes the ability to distinguish between the operational demands of a role and the need for a strategic approach to development. It implies that leaders do not become lost in operational detail. It also implies that leaders are reflective thinkers, with a defined philosophy based on values. In this way, leaders create meaning and provide opportunities for people to learn.

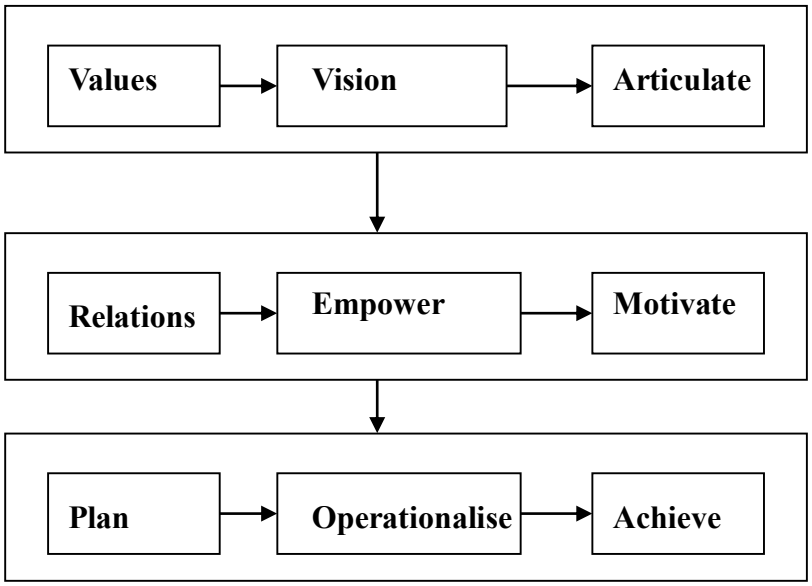
Second, leaders are also individuals who are good at building **relations** with others. As managers, they **empower** those around them and **motivate** them to high standards of performance and achievement. The capacity to relate, empower and motivate is thus a key competence in a leader. It includes skills such as the ability to read the environment, particularly the political and policy environment, and the possession of a high degree of political astuteness. It also includes the ability to cooperate and collaborate across the organisation, across the professional disciplines and across organisational boundaries. Leaders are people who inspire trust and confidence in those with whom they come in contact and they manage the use of power within organisations in a way that engenders this trust. In this capacity they act as process consultants, bringing together different aspects of the organisation towards the achievement of the vision. It involves, therefore, a multi-disciplinary approach that is non hierarchical and that respects the contribution of each discipline to the achievement of the overall vision. Relationship building also entails the development of mentoring and support mechanisms aimed at addressing issues of succession and the emergence of future leaders.

Third, leaders are individuals who **plan** their way forward and are capable of **operationalising** their vision in a manner that focuses on **achievements** and results. Leaders are results focused and outcomes oriented. This includes a deep understanding of the business side of organisations and the importance of harnessing all of the business disciplines towards the achievement of the vision. It also includes the ability to work in an independent and accountable manner. This implies that nurse leaders need to broaden their skills and educational base to include experience in and training in disciplines that are not part of the clinical set of skills for nurses. It also involves linking individuals and

their skills sets with the appropriate tasks that need to be done. Planning also entails the provision of arrangements capable of preparing future leaders and ensuring that they receive the necessary mentoring and support.

The following diagram (figure 3.1) summarises the key competencies and levels of activity involved in leadership:

Figure 3.1: Competencies and Activities relevant to Leadership in Nursing and Midwifery



A leader is someone who is in possession of a system of values that form the basis for the articulation of a vision. A leader is also in possession of an active network of relations within and outside the organisation and, through the articulation of the vision, empowers and motivates those around him / her. The system of relations and networks provides the structures within which a plan can be conceived, operationalised and delivered. This model of leadership is driven by vision, with empowerment at its centre and focused on achievements.

The next section of this chapter will examine the need for a strategic framework for the development of the profession of nursing. The development of strategy will provide the overarching context within which nurse and midwife leaders can work to empower themselves and others.

3.4 Strategic Planning

The Report of the Commission on Nursing provided a blueprint for the development of the profession and has resulted in great progress being made over the last 10 years. There does not exist in Ireland at the moment however, a comprehensive strategy for the development of the profession of nursing and midwifery. This thesis will seek to provide the basis for the formulation of such a strategy (chapter 8). In this section of this chapter, examples of strategies that have been developed elsewhere will be examined and lessons will be drawn from the experiences of strategic planning for the profession. In the first instance, a brief review of a number of strategies that have been developed by the WHO in Europe will be presented. Then, a number of strategies developed by our close neighbours in the United Kingdom, (England, Scotland, Wales and Northern Ireland) will be reviewed. Canadian nursing and midwifery also has a tradition of strategic planning and a brief review of some of the recent examples of this will be presented. This section will conclude with some brief reflections on the lessons that can be learned from the international examples.

3.4.1 The WHO in Europe

In 1993, the WHO produced a report entitled *Nursing in Action – Strengthening Nursing and Midwifery to Support Health for all* (WHO, 1993). The report emerged from the work of a group of experts throughout Europe who set out to

build on the decision taken by the participants at the 1988 WHO European Conference on Nursing, to choose the strategy for health for all as the guiding star for the development of the profession. They set themselves the goal of creating a new kind of nurse, who will be an autonomous, skilled practitioner who can work alone or in partnership with other professionals to deliver primary health care in any setting. The role will not be to serve another profession but to inform, support and care for the patient and the community. The book contains advice and guidance that can assist nurses throughout Europe in developing this role by creating the necessary support structures, establishing regulatory systems, reforming education, preparing leaders and managing change. It is a guide to practice and professional development.

The book identifies four major functions that are at the core of nursing. These are (WHO, 1993):

1. Providing and managing nursing care, which includes actions that are promotive, preventive, curative, rehabilitative and supportive, to individuals, families or groups. This is most effective when it follows the logical steps inherent in the nursing process.
2. Teaching patients or clients and health care personnel.
3. Acting as an effective member of a health care team.
4. Developing nursing practice through critical thinking and research.

It is based on an understanding of the implications of these core functions that strategies and approaches to education, regulation, practice development and professional development should be developed.

In 1995, a WHO Expert Committee on Nursing Practice (WHO, 1996) met in Geneva with the objective of defining strategies for change to ensure that nursing practice, consistent with the principles of primary health care, were developed with the genuine participation of the community. To achieve this, the Expert Committee set out to describe the core elements of nursing practice; to specify the nature and scope of nursing practice in countries at different stages of socio-economic development; to identify the implications for, and action

needed with regard to basic nursing education, continuing nursing education, management of health services, legislation and regulation, working conditions and research; and, to consider the implications for, and action needed with regard to the development of health services and human resources. The committee reviewed the definition of what nursing is (as reported in chapter 2, 2.7) and went on to make a series of recommendations for the WHO and for the Member States of the WHO.

In the case of the Member States, the Committee recommended in particular that strategies should be developed that will enable nursing and midwifery personnel to provide comprehensive and integrated primary, secondary and tertiary health care. The Committee also endorsed the recommendations contained in the report *Nursing Beyond the year 2000: Report of a WHO Study Group* (WHO, 1994), which had made a series of recommendations for the WHO and for the Member States of the WHO. The recommendations were intended to promote within Member States a new multi-sectoral systems approach to health care delivery and full collaboration of health care personnel at all levels; a shift in the focus of the workforce development in nursing and midwifery to reflect country health needs, with particular emphasis on vulnerable groups; and a revitalisation and reorientation of nursing and midwifery education and practice to meet the challenges of the future.

Among the recommendations, the Working Group highlighted that an important dimension of strategic planning for nursing and midwifery is the creation of a multi-sectoral forum of relevant partners involved in practice, research, education, management and policy development for nursing and midwifery services, in order to address the changing needs of nursing and midwifery personnel, their preparation and the development of educational systems that allow personnel to move from one career level to another (WHO, 1994). Among the recommendations were also the need for flexible and enabling regulation and legislation and the creation of a variety of educational and career pathways for nurses and midwives.

In 1997, as part of its collaborative programme for the development of healthcare personnel, the WHO produced *A Strategy for Nursing and Midwifery Development in the Eastern Mediterranean Region* (WHO, 1997). The Strategy provides a useful framework for the development of such strategies. It is based on the position that quality nursing and midwifery services, both in the hospital and the community health setting, are one of the main pillars of health system development and achieving health for all. The Strategy provides a vision for nursing in the region; analyses the context and stakeholders in the region, identifying the strategic issues facing each of them; identifies objectives, action points and targets for the regulation of nursing practice, nursing education, nursing leadership development, nursing research, nursing and technology and nursing structure. A similar exercise was conducted in 2003 in Iraq, as a collaborative venture between the Ministry of Health-Iraq, the Coalition Provisional Authority and the WHO. Entitled *National Strategy and Plan of Action for Nursing and Midwifery Development in Iraq 2003 – 2008* (WHO, 2003), the document applies the same strategic framework to the complex setting of that war torn country, emphasising in particular the need for clear objectives, action points and targets with dates by which they should be achieved.

In 1999 the WHO produced *Nurses and Midwives for Health: A WHO European Strategy for Nursing and Midwifery Education* (WHO, 1999). The Strategy was developed in response to what was perceived as the increasing complexity of the environment in which nursing and midwifery had to operate. The Strategy set out a number of principles that should guide the development of nursing and midwifery education and also provided guidance for the development of a curriculum. Among the recommendations included in the strategy was a list of supporting subjects that should be included, as a minimum, in the curriculum, making explicit their application to nursing and midwifery. These included (WHO, 1999):

- Public health, health promotion, health education and therapeutic patient education.

- Social and behavioural sciences.
- Biological sciences.
- Research awareness.
- Communication.
- Professional, ethical and legal issues.
- Information management and information technology.
- Management, leadership and organisation.

In 2002, in response to growing imbalance and shortages of nursing and midwifery personnel in Member States, the WHO produced *Nursing Midwifery Services: Strategic Directions 2002 – 2008* (WHO, 2002). The *Strategic Directions* document was intended as a framework for collaborative action to support countries in enhancing the capacity of nursing and midwifery services to contribute to national health goals. The document identified five key result areas, each with specific objectives and expected results. The five key result areas were:

1. Health planning, advocacy and political commitment: National development and health plans provide for adequate nursing and midwifery services and expertise.

2. Management of health personnel for nursing and midwifery services: National employment policies are implemented for the nursing and midwifery workforce that are gender sensitive, based on healthy and safe work environments and conditions, provide for equitable rewards and recognition of competencies, and are linked to a transparent career structure.

3. Practice and health system management: Nursing and midwifery expertise is fully integrated into decision-making processes at all levels, and health systems use best available practices for the care of individuals, families and communities.

4. Education of health personnel for nursing and midwifery services: Competent practitioners with an appropriate skill mix are available to deal effectively with the current and future challenges of practice.

5. Stewardship and governance: Stewardship and governance of nursing and midwifery services involve the government, civil society and the professions to ensure the quality of care.

3.4.2 United Kingdom

In England, in 1999, as part of the Labour Governments plans for increased investment in the NHS (outlined later in *The NHS Plan: A Plan for Investment, A Plan for Reform* (DoH, 2000)), the Department of Health produced a document that outlined what the Government's strategic intentions were for nursing, midwifery and health visiting. This was entitled *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (DoH, 1999). The document describes a number of measures to be taken by the Government to strengthen the role and contribution of the professions to the delivery of healthcare, within a career framework that involved four steps similar to those identified by Castledine (1996) as the four domains of nursing (discussed already in chapter 6, 6.2). It contained a number of what it described as *Early Milestones* (DoH, 1999) for the period 1999/2000, by which to measure progress. These included provisions for the improvement of pay and conditions for nurses, midwives and health visitors; an increase in the numbers of nurses, midwives and health visitors; an increase in the number of training places; and a number of provisions in the area of professional development. Among the latter were:

1. Guidance about the establishment of nurse, midwife and health visitor consultant posts.
2. Explore the benefit of clinical practice benchmarking with the nursing, midwifery and health visiting professions.
3. Take forward nurse prescribing.
4. Publish plans to show how nurses, midwives and health visitors will have access to programmes to strengthen leadership and management across the NHS.
5. Begin the process of preparing for new legislation for professional self regulation.

6. Implement a programme to develop the public health aspects of nursing, midwifery and health visiting.
7. Work with women, midwives and others to explore opportunities for an expanded midwifery role.
8. Publish plans for the better management of NHS funded education in which the Department of Health will take on a more active and wider role.
9. A strategy to influence the research and development agenda, strengthen the capacity to undertake nursing, midwifery and health visiting research, and to use research to support practice.
10. Personal development plans for nurses, midwives and health visitors.
11. New model of nurse education.
12. Partners Council to explore and make recommendations about potential for greater standardisation of roles and titles.
13. Partners Council to advise on pre and post-registration education.

In Scotland, in 2001, the Scottish Executive Health Department produced a strategy for nursing and midwifery in Scotland entitled *Caring for Scotland: The Strategy for Nursing and Midwifery in Scotland* (Scottish Executive Health Department, 2001). The document identified a number of key drivers for the strategy. These were:

- Accountability, support and supervision
- Leadership
- Professional development
- Career development and workforce planning
- Research, evidence based practice development and innovation
- Education.

The strategy (Scottish Executive Health Department, 2001) identified a number of action points, which provide a useful summary of the key issues it set out to address. The key action points were identified under the following headings:

1. Supporting children and families through a network of carers and professionals.
2. Supporting people with learning disability.
3. Supporting older people.
4. Defining competencies in forensic nursing.
5. Working to promote social justice in communities.
6. Supporting patients in the community.
7. Supporting nurses in remote and rural areas.
8. Improving services for patients with chronic disease.
9. Assessing the impact of nurse and midwife consultants.
10. Setting new standards in Emergency Department Nursing.
11. Piloting the family health nursing role.
12. Developing nurse prescribing roles.
13. Monitoring role expansion.
14. Enhancing professional accountability.
15. Developing clinical supervision.
16. Building networks for isolated practitioners.
17. Supporting newly qualified nurses and midwives.
18. Improving supervision for midwives.
19. Training, supporting and supervising support workers.
20. Developing leaders in nursing and midwifery.
21. Recognising the significance of ward sisters / charge nurses.
22. Enhancing professional development.
23. Developing competency based frameworks.
24. Creating options for student nurses.
25. Expanding career pathways.
26. Addressing issues in workforce planning.
27. Promoting research, evidence based practice, development and innovation.
28. Addressing issues in nurse and midwifery education.

In Wales, in 1999, the National Assembly for Wales produced a document entitled *Realising the Potential: A Strategic Framework for Nursing, Midwifery and Health Visiting in Wales into the 21st Century* (National Assembly for Wales,

1999). The document stated that the strategic goal for the professions was to realise the full potential of nursing, midwifery and health visiting in order to meet, in collaboration with others, the future health needs of people in Wales. It provided a description of the key characteristics of nursing, midwifery and health visiting in the future, a description of what the health services of the future would be like and identified a number of supporting aims that would contribute towards the achievement of the strategic goal. These supporting aims were (National Assembly for Wales, 1999):

1. Improving the environment of care: To ensure that nurses, midwives and health visitors coordinate the environment of care for their patients and clients, thereby ensuring, through collaboration with others, that all appropriate resources are centred on the patient / client.
2. Ensuring high quality service for all: To ensure that high quality nursing, midwifery and health visiting care reaches all those in need, whether rich or poor, wherever they may be, to promote good health, and to prevent, cure or relieve suffering, with the client / patient as an equal partner in care.
3. Encouraging independent and reflective practice: To ensure that all nurses, midwives and health visitors develop their practice in a reflective and evidence based manner, founded upon a standard of education which enables them to practice as equal partners with other healthcare professionals, supported by continuing professional development and clinical supervision.
4. Developing existing and new career paths: To develop existing and new career paths for nurses, midwives and health visitors which allow senior staff to remain clinically involved if they so wish, and which break down unhelpful barriers between education, research and practice, as well as, between nursing, midwifery and health visiting and the wider health care context.
5. Demonstrating the value of nurses, midwives and health visitors: To demonstrate the value of nursing, midwifery and health visiting so that the professions themselves, together with their colleagues and the service as a whole, appreciate the particular contribution which these professions make to the health of patients and clients.

In 2003, the Department of Health, Social Services and Public Safety (DHSSPS) of Northern Ireland, published *Valuing Diversity… A Way Forward – A Strategy for Nursing, Midwifery and Health Visiting – 1998 – Summary of Achievements 1998 – 2003* (DHSSPS, 2003). This document consisted of a review of the achievements in implementing the strategy that had been developed in 1998. The original strategy had identified actions in a number of key areas: Commissioning; Practice; Education; Research and Development; Leadership and Management. The DHSSPS has also published a number of papers on the contribution of nursing to public health. These papers have been prepared jointly with the DoHC in Dublin, and represent an attempt to identify on an all island basis strategies for improving the contribution of nursing and midwifery to public health. There have been three papers so far: (1) *A Nursing Vision of Public Health* (DHSSPS & DoHC, 2001); (2) *From Vision to Action – Strengthening the Nursing Contribution to Public Health* (DHSSPS & DoHC, 2003); (3) *Nursing for Public Health – Realising the Vision* (DHSSPS & DoHC, 2005). In addition, the DHSSPS has published the strategy document *A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland* (DHSSPS, 2004), which provides a strategic framework for the health services and for the development of healthcare professions into the future.

In 2005, the four United Kingdom Chief Nursing Officers (CNO) established the modernising nursing careers initiative. A UK wide group of nursing leaders formed the Modernising Nursing Careers Board, chaired by the CNO of England. The organised a series of national stakeholder workshops and events and consulted widely within nursing and midwifery in all of the four countries of the UK. Their report *Modernising Nursing Careers: Setting the Direction* (DoH, 2006), presents the outcome of their discussions. The four countries committed themselves to taking forward the priorities for action contained in the report aimed at modernising nursing careers. The report contains a description of what modern careers in nursing should be like. The characteristics they identified included (DoH, 2006):

1. An up to date picture of nursing careers characterised by opportunity and diversity.
2. Care taking place in and outside hospital with the workforce moving between them and nurses starting their career in the community.
3. A career framework that allows nursing to 'grow its own' with multiple entry points for those taking up nursing as a second career or as mature entrants.
4. Plurality of provision offering alternative employers and employment models including NHS Foundation Trusts, self employment and social enterprises.
5. A flexible principle-based curriculum that is built around patient pathways, with a strong academic foundation and interdisciplinary learning.
6. A framework that supports movement between career pathways, practice, management and education and that values and rewards different career types.
7. Better balance of generalists and specialists to provide integrated networks of urgent, specialist and continuing care.
8. Careers built around patient pathways using competence as the currency for greater movement and flexibility.
9. A career structure with increased number of assistants working as part of multidisciplinary teams.
10. Standardisation of advanced level skills.
11. Patient pathway-based careers focusing on nursing roles rather than titles.
12. Nursing roles defined according to patient need – to provide intervention that is timely, accurate and swift.
13. Nursing teams more self-directed and professionally accountable.
14. Nurses leading, coordinating and commissioning care, as well as giving care, to bring about change measured by health gain and health outcomes.
15. Care based on evidence and critical thinking and assisted by new technology.

3.4.3 Canada

Canada's first nationwide nursing strategy was developed in 2000 as a response to a severe shortage of nursing personnel. The strategy, entitled *The Nursing Strategy for Canada* (Advisory Committee on Health Human Resources, 2000) had as its goal the achievement and maintenance of an adequate supply of nursing personnel to meet the needs of the Canadian healthcare system. The strategy called for concerted action between all the provincial / territorial authorities who are responsible for the provision of healthcare in their respective geographic areas to address the challenges. In 2003, *A Report on the Nursing Strategy for Canada* (Ministry of Public Works and Government, 2003) contained an analysis of the progress that had been made since the publication of the first strategy. The report noted that a great deal had been achieved in terms of knowledge development and sharing, multi stakeholder cooperation and a recognition that the problem of ensuring a continuing supply of nursing resources is a national concern. The report however pointed to the continued problem of lack of information to permit comprehensive workforce planning for nursing resources to take place. The report also pointed to the need to focus on improving how and where nurses practice, which has an effect both on the success in encouraging people to choose nursing as a profession and on their choosing to stay in the profession for the duration of their work lives.

In 2005, a pan-Canadian steering committee consisting of representations from the various branches of the nursing professions, employers, unions, educators, physicians and provincial and territorial governments, produced a final report on phase 1 of a project entitled *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada* (Pan-Canadian Steering Committee, 2005). The goal of the project was to create an informed, long term strategy to ensure an adequate supply of skilled and knowledgeable nurses to meet the evolving and changing health care needs of all Canadians. The report recognised that health system restructuring over the past 10 years had had a negative impact on nurses, resulting in significant changes in the nursing workforce. According to the report, health care organisations have struggled to cope with health reform, fiscal challenges and changes in the nursing workforce by implementing policies that have had a negative impact on the quality of work-

life of professional nurses. This includes, for example, increased involuntary and unpaid overtime for nurses, casualisation of the nursing workforce, increased use of unregulated health care providers and increases in workloads. These developments have resulted in a growing dissatisfaction among professional nurses and many have chosen to leave the profession. The report also stated that it was now recognised that these changes in the professional work-life of nurses were having a detrimental impact on the quality of patient care. The report makes 10 recommendations to address the priorities identified in the research. The recommendations are based on three broad categories of health human resources: health human resources planning; retention and recruitment; and inter-professional education for collaborative patient centred practice. The similarities between the situation described in Canada and what has happened in Ireland over recent years of reform and change in the health services are striking.[9]

3.5 Conclusion

In this chapter a number of important strategic issues facing nursing and midwifery in Ireland have been identified. These include the need for strategies to address the challenges of recruitment and retention of nurses and midwives in the future. If nursing and midwifery is to be able to recruit and retain the right kind of professional staff, it will require the development of a culture of empowerment, led by nurse and midwife leaders. Strategic planning for the profession is required and examples from abroad point to a number of lessons that can be learned. There are many lessons from this material that are directly relevant to the current situation in which nursing and midwifery finds itself, in the midst of a radical reform of the health services.

The following conclusions suggest themselves from the material presented in this chapter:

[9] See discussion of recruitment and retention (3.2) and empowerment (3.3.2)

1. The importance of a coordinated approach at national level to planning for the future of nursing and midwifery emerged from all of the strategic documents reviewed. Regardless of the nature of the political and administrative system within a country, planning for nursing and midwifery is a national priority. This is clear from the recommendations of the WHO (WHO, 1994), the experience of coordinated approaches in the UK by the Chief Nursing Officers (DoH, 2006) and the experience of the Canadian Federal system.

2. There is a need for rolling strategic planning in nursing and midwifery at national level. This should be based on a clear understanding of the way in which the environment is evolving, a vision of what is required, a clear set of objectives, targets with timeframes for delivery and clear allocation of responsibilities for delivery. Strategies need to be inclusive of all stakeholders and should evolve over time to reflect changing needs. Strategies need to be future-focused, based on an analysis of trends in society and in service development and a description of the likely shape of the health services of the future. Strategies should also focus on the competencies that will be needed to address the future needs.

3. Nurses and midwives need to be involved at every level of the planning and development of policies and delivery mechanisms, at national, regional and local levels. Nurses and midwives need therefore, to develop the competencies required to contribute at this level and their inputs at the decision making table needs to be facilitated and developed.

4. Nursing and midwifery needs to develop a strong sense of professional identity as a basis for the development of nurse led, autonomous services related to client / patients needs and service development priorities. The professions should develop as integrated partners with other professionals and healthcare workers, participating as members and, where appropriate, as leaders of these teams.

5. The role of nursing and midwifery is evolving in a dynamic way in response to increased complexity in the environment (political, administrative, financial, technological, cultural). This has implications for the way in which nurses and midwives are educated for entry to the profession and for the ongoing professional development support they need to fulfil their role. Curricula for nurse education at pre and post-registration levels need to reflect this. Nurses and midwives require broad based education aimed at developing competencies that evolve in line with the needs of the service. Nursing as a science is based on research, evidence based practice, specific knowledge and skills. Nursing as an art is based on intellectual and emotional competencies that form the basis of reflective practice and the development of wisdom and judgement. Nursing practice needs to expand its boundaries based on clear guidance on scope of practice and on the basis of competency frameworks supported by adequate education and professional development.

6. There is a need for a planned and strategic approach to the development of generalist, specialist and advanced practice in nursing and midwifery. The important role of the nurse / midwife at all levels must be maintained, as the principal coordinator of care in a health care setting. This must be based on a rich career pathway that covers clinical, management, education and research opportunities. Career pathways should be integrated to enable flexible movement between and within the pathways, encouraging linkages and close relationships between all of the pathways.

7. Nursing and midwifery must have strong roots in the community. Primary care is increasingly becoming the principal forum for the delivery of nursing and midwifery services where they can be close to patients and clients and develop their presence by providing a unique set of services that are tailored to the needs of patients and clients. This implies proactive involvement in the implementation of the recommendations of the various reports that have been prepared on these issues (e.g. The report on bed utilisation prepared by P.A. Knowledge Management, 2007 and the report

on the action plan for health services in the North East prepared by Teamwork Management Services Ltd., 2006)

8. Planning for an adequate workforce in nursing and midwifery requires the development of information systems at a national level that permit the development of strategies for recruitment and retention based on workforce planning. This includes planning the work environments in which nurses and midwives work in a manner that takes account of the need for safety and encourages nurses and midwives to develop to their full potential. Planning for nursing and midwifery resources needs also to take account of the importance of flexible gender sensitive policies. Planning of this kind is particularly important at times of health service reform to ensure that undue stress is not put on the nursing and midwifery workforce.

The conclusions reached in this chapter provide an important framework for the consideration of a strategy for the professional development of nursing and midwifery in Ireland. This will be addressed in chapter 8 of this thesis. The following chapters (chapters 4, 5, 6 and 7) will be dedicated to the primary research that will underpin the formulation of this strategy.

Chapter 4 – Methodology

4.1 Introduction

The purpose of this chapter is to describe in detail the methodology that was chosen for this research.

The choice of methodology used in this study was driven by a number of key factors. These factors provide us with the outline of this chapter. They are:

1. The aims of the research: The first step in any research exercise is to define clearly the questions to be addressed by the research. The nature of the information to be obtained has a fundamental bearing on the methods to be used for collection and analysis.

2. The theoretical framework for the research methodology: This entails an explicit identification of the conceptual framework within which the methodology was designed, including an identification of the assumptions implicit in this framework and the implications of the framework. This assisted in identifying the guidelines used in the selection of research methods.

3. Analysis of the nature of the information to be gathered and the likely sources of that information. This is necessary in order to be able to define the data collection methods to be used.

4. The population to be targeted for the research and the sampling techniques chosen.

5. Gaining access to the targeted sample within the population and scheduling data gathering events.

6. The research instruments that were used in addressing the selected sample: In effect this involved a more detailed analysis of the methods of

data collection with particular emphasis on the instruments likely to be most suited for the purposes of the research.

7. The data analysis techniques used: The definition of these techniques was determined by the nature of the data.

8. Ethical issues associated with the research to be conducted.

The principal purpose of this chapter is to address these issues and to provide a description of the basis on which the research at the heart of the study was conducted. Sections 4.2 to 4.9 provide a detailed description of the approach taken under each of the headings listed above.

Section 4.10 of this chapter provides some reflections on the practical application of the methodology. This section describes the experience of coding a large amount of qualitative data, how validity and reliability were guaranteed and how the ethical issues raised in section 4.9 were dealt with in practice. The section concludes with an introduction to the data chapters that follow on the presentation and discussion of the results of the research.

4.2 Aims

The research set out with two principal aims:

- To identify the future role for nursing and midwifery within the Irish health services as perceived by key stakeholders within the services.

- To identify the professional development implications for this role.

These aims were subsequently broken down into a number of objectives (13). These were to:

1. Identify and analyse the contexts (policy, economic, organisational, and institutional) within which the health services of the future will be delivered

2. Describe the likely future shape of the Irish health services

3. Describe as clearly as possible the new role that is intended for nurses and midwives within the services

4. Describe in what way this role differs from the current role

5. Assess the degree of clarity and certainty (or of confusion and uncertainty), of awareness and understanding that exists in relation to the definition of this role among key stakeholders

6. Describe the nature of the relationships that will need to be developed within new institutional and service delivery settings

7. Identify the skills and competencies that will be required to fulfil the new role

8. Assess whether these skills and competencies differ from those that are currently required

9. Assess perceptions as to whether nurses and midwives currently possess the necessary skills and competencies

10. Assess the level of preparedness of nurses and midwives to work within the dynamics of the new relationship and contexts

11. Assess the adequacy of the current provision of professional development opportunities for nurses and midwives (at pre-registration and post-registration levels) to prepare them for the challenges inherent in the new role that is envisaged for them

12. Identify what changes would be required to the provision of professional development opportunities to ensure that in the future nurses and midwives are adequately prepared for their role

13. Formulate a professional development strategy for nursing and midwifery adapted to the likely pace of change within the health services and capable of addressing the needs of the professions

All the subsequent field research (interviews, focus groups) was driven by these objectives. It will become clear that they also provided the basis for the definition of the themes, categories and codes that emerged in the analysis of the data that were collected (section 4.10).

4.3 Theoretical Framework for the Research Methodology

The object of research in this study is nursing and midwifery. More particularly, it is an analysis of nursing and midwifery within a health service in Ireland that is undergoing extensive change. The purpose of the research is to understand in what way the changes that are occurring within the health services are impacting on the role of nursing and midwifery now and, more importantly, into the future. This understanding will provide the basis for the definition of a strategy for the development of the professions of nursing and midwifery to enable them to cope with the impact of these changes.

This description of the object and purpose of the research to be conducted in this study provides the basis for determining the best research strategy to adopt. Once a research strategy has been chosen, the specific methods of research that are most appropriate to use will then become more apparent.

The overall research strategy that appeared to be most appropriate for this study is the case study. Stake (2003) points out that a case study is not a methodological choice, but a choice of what is to be studied. Once the object of the study has been chosen, one can then choose to use a variety of methods that are appropriate to the object of the study.

Stake describes the characteristics of a case study approach as one where the object of the study is a specific, unique, bounded system (Stake, 2003). In this case, nursing and midwifery constitute a specific, unique bounded system within the health services. In addition, the system is being considered in the context of the changes that are occurring within the health services.

To say that nursing and midwifery is a "bounded system" implies that the behaviour of nurses and midwives is patterned. There is a coherence and sequence evident within the profession; this is due to the regulated nature of the professions and the degree of professional training and education that is required to become a nurse or midwife. It is therefore easily identifiable as an object of case study as described by Stake (2003).

The epistemology underpinning this research is one in which the world is viewed as a whole, an interactive system with patterns of information exchange between subsystems or levels of reality (Downs, 1999). In this sense it is multi-dimensional and comprises multiple levels, with potential for interaction across levels and between levels. Levels exist within the whole and are interactive so that changes on one level reverberate between levels. A stratification of these levels for the health sciences would include cellular, organ system, person, family, community, culture and society (Downs, 1999). Each clinical area focuses on a primary level depending on its competence. However, all must be aware of the interactivity of the whole. Analysis of data within such a system includes both quantitative observations and data and qualitative observations and data.

Similarly, within such a system, both subjective and objective data are recognised as legitimate avenues for gaining understanding. In a world that is considered as a multidimensional interactive whole, the validity of data cannot be denied based on its source. Therefore, consistent with the paradigm of an interactive system, the concept of 'research participant' includes not only those who are the subjects of the methodology but also those who administer or operate the methodology. Artificial attempts to maintain an observer neutral stance can only serve to reinforce a sense of false security. It is impossible to

eliminate investigator bias totally, therefore it makes more sense to recognise it and integrate it consciously into the methodology. Thus, recognition of contributions from both the investigator and the subject is increased when the interaction between the two is acknowledged.

This paradigm also implies that both atomistic and holistic thinking will be used in research design and analysis. It is important to combine reflections based on analysis of the individual parts of the system with considerations derived from a consideration of the overview.

Stake (2003) states that the epistemological question driving the conduct of the case study is what specifically can be learned from the single case. This raises the question as to whether the case study is to serve as a basis for generalised conclusions to be made, either as a contribution to theory, or as a contribution to understanding other cases. This thesis is not intended as a contribution to theory, in the same way as a grounded theory (Locke, 2001; Duffy et al, 2004) approach might be. Neither is it interested in the question of generalised conclusions to be made that could be of use in other cases. It intends to be “an intrinsic study of a particular case” (Stake, 2003). The design of the research is aimed at understanding what is important about the case in its own world. We will seek to make generalisations, it would be impossible not to do so. But these will largely be in relation to happenings and issues within the case itself, relative to the future of the case and new situations that may arise (Stake, 2003).

Context and situations are important elements of a case study. The case has its own unique history and operates within a number of contexts such as institutional, physical, economic, legal, administrative, and ethical. The case is singular but it has subsections (e.g. branches of the profession, grades of expertise, levels of specialisation), groups (e.g. students, educators, managers, specialists), occasions (e.g. registration, graduation, advancement to another level of speciality, ongoing education), and what Stake refers to as a concatenation of domains – many so complex that at best they can only be sampled (Stake, 2003).

Lincoln and Guba (2003) point out that a holistic case study calls for the examination of these complexities. They point out that much qualitative research is based on a holistic view that social phenomena, human dilemmas, and the nature of cases are situational and influenced by happenings of many kinds. To tackle this complexity, qualitative research in case study is usually organised around issues (Stake, 2003). These issues can be organised around a number of research questions. In this research, these questions have been identified in the aims and objectives of the research. They include issues such as the impact of the changes in the health services on nursing and midwifery, the implications of these changes for skill sets, the implications of these changes for role development and for professional development. The identification and articulation of these issues in this research, further emphasises the intrinsic nature of the research being conducted in this study.

The complexity of the contexts and situations involved and the need for a holistic approach to identification of issues that will serve to provide structure to the case study raise the issue of the validity of the observations, descriptions and conclusions. One method of tackling this need for validity is triangulation. Janesick (2003) refers to ‘data triangulation’ as the use of a variety of data sources in a study. This raises the question of providing corroboration of an interpretation, or appreciating the complexity of an issue by looking at it from a number of different perspectives. This question of perspective is described by Janesick (2003) as better represented by the concept of ‘crystallisation’. Crystallisation recognises the many facets of any given approach to the social world as a fact of life. According to Richardson (1994), the crystal combines symmetry and substance with an infinite variety of shapes, substances, transmutations, multidimensionalities, and angles of approach. Crystals grow, change and alter but are not amorphous… crystallisation provides us with a deepened, complex, thoroughly partial, understanding of the topic. Paradoxically, we know more and doubt what we know (Janesick, 2003).

With these observations in mind, it is possible to summarise the major responsibilities of the case study researcher as follows (Stake, 2003):

1. Bounding the case, conceptualising the object of the study
2. Selecting phenomena, themes or issues – that is, the research questions – to emphasise
3. Seeking patterns of data to develop the issues
4. Triangulating or crystallising key observations and bases for interpretation
5. Selecting alternative interpretations to pursue
6. Developing assertions or generalisations about the case.

According to Stake (2003), the purpose of the case study is not to represent the world but to represent the case. He also asserts that the case study approach can be a disciplined force in public policy setting and reflection on human experiences, as vicarious experience is an important basis for refining action, options and expectations (Stake, 2003).

4.4 Data to be Gathered and Sources

The most appropriate data collection methods to use in this study were determined principally by the nature of the questions that were addressed and the characteristics of the subjects of the research. Because of the scope and complexity of the research, qualitative research methodology was used.

With this in mind, each of the objectives of the research was considered in turn in order to identify the most appropriate methods in each case. An analysis of these considerations is provided in Table 4.1 below. The table describes for each objective the most likely source of the answers to the questions that will be posed. In each case, data collection methods are suggested that appear to be most appropriate given both the nature of the information that is sought and the likely source.

Table 4.1 – Research Objectives, Sources, Methods

No.	Research Objective	Source	Research Method

No.	Research Objective	Source	Research Method
1)	Identify and analyse the contexts (policy, economic, organisational, and institutional) within which the health services of the future will be delivered.	Educators Policy Makers Service Managers Medical Consultants Nurse Managers	Focus Groups Semi-structured interviews Review of best practice elsewhere
2)	Describe the likely future shape of the Irish health services	Documents Educators Policy Makers Service Managers Medical Consultants Nurse Managers	Review of Policy Documents; review existing statistical forecasts for economy and demographics; review best practice elsewhere Focus Groups; Semi-structured interviews
3)	Describe as clearly as possible the new role that is intended for nurses and midwives within the services	Documents Educators Policy Makers Service Managers Medical Consultants Nurse Managers	Review of Policy Documents Review best practice elsewhere Focus Groups Semi-structured interviews
4)	Describe in what way this role differs from the current role	Service Managers Educators Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives	Focus Groups Semi-structured interviews Secondary analysis of existing research on specialist nurses and midwives, ANPs and staff nurses / midwives by National Council.
5)	Assess the degree of clarity and certainty (or of confusion and uncertainty), of awareness and understanding that exists in relation to the definition of this role among key stakeholders	Service Managers Educators Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives	Focus groups Semi-structured interviews Secondary analysis of existing research on specialist nurses and midwives, ANPs and staff nurses / midwives by National Council.
6)	Understand the nature of the relationships that will need to be developed within new institutional and service delivery settings	Service Managers Educators Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives	Focus Groups Semi-structured interviews Review of best practice elsewhere.

No.	Research Objective	Source	Research Method
7)	Identify the skills and competencies that will be required to fulfil the new role	Service Managers Educators Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives	Focus Groups Semi-structured interviews Secondary analysis of existing research on specialist nurses and midwives, ANPs and staff nurses / midwives by National Council.
8)	Assess whether these skills and competencies are different from those that are currently required	Service Managers Educators Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives	Focus Groups Semi-structured interviews Secondary analysis of existing research on specialist nurses and midwives, ANPs and staff nurses / midwives by National Council.
9)	Assess perceptions as to whether nurses and midwives currently possess the necessary skills and competencies	Service Managers Educators Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives	Focus Groups Semi-structured interviews Secondary analysis of existing research on specialist nurses and midwives, ANPs and staff nurses / midwives by National Council.
10)	Assess the level of preparedness of nurses and midwives to work within the dynamics of the new relationship and contexts	Service Managers Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives Educators	Focus Groups Semi-structured interviews Secondary analysis of existing research on specialist nurses and midwives, ANPs and staff nurses / midwives by National Council.
11)	Assess the adequacy of the current provision of professional development opportunities for nurses and midwives (at pre-registration and post-registration levels) to prepare them for the challenges inherent in the new role that is envisaged for them	Service Managers Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives Educators	Focus Groups Semi-structured interviews Secondary analysis of existing research on specialist nurses and midwives, ANPs and staff nurses / midwives by National Council.
12)	Identify what changes would be required to the provision of professional development opportunities to ensure that in the future nurses and midwives are adequately prepared for their role.	Service Managers Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives Educators	Focus Groups Semi-structured interviews Secondary analysis of existing research on specialist nurses and midwives, ANPs and staff

No.	Research Objective	Source	Research Method
			nurses / midwives by National Council. Review of best practice elsewhere
13)	To formulate a professional development strategy for nursing and midwifery adapted to the likely pace of change within the health services and capable of addressing the needs of the profession.	Policy Makers Service Managers Medical Consultants Nurse Managers Specialist Nurses Staff Nurses and Midwives Educators	Focus Groups Semi-structured interviews Secondary analysis of existing research on specialist nurses and midwives, ANPs and staff nurses / midwives by National Council. Review of best practice elsewhere

4.5 Populations, Samples and Data Collection Methods

The information contained in table 4.1 enables the identification of the following categories of relevant key stakeholders that could be considered subjects for the research to be conducted. These are as follows:

1) Policy Makers
2) Service Managers
3) Medical Consultants
4) Educators
5) Directors of the Nursing and Midwifery Planning and Development Units (NMPDUs)
6) Directors of Nursing and Midwifery (hospital and community)

National strategy in nursing and midwifery will be driven principally by the members of these categories of stakeholders. For that reason they constituted the most important targets for the primary research conducted as part of this study.

Other important categories include –

7) Assistant Directors of Nursing / Midwifery

8) Clinical Nurse / Midwife Managers (CNMs/CMMs – grades 1, 2, 3)
9) Specialist nurses (including Clinical Nurse / Midwife Specialists – CNS / CMS, and Advanced Nurse / Midwife Practitioners (ANP / AMP)
10) Staff Nurses / Midwives

For the purpose of defining institutions and individuals for inclusion in the sample used in the research, the following general criteria were applied –

1) **Policy Makers** – It was possible to identify a core group of individuals in key posts involved in determining the shape of health services in the future and the role of nursing within those services. A purposive sampling approach was adopted here aimed at ensuring inclusion of key decision influencers in the policy making area for the health services. The sample includes –
   a. Secretary General (DoHC);
   b. Assistant Secretary responsible for Strategy Implementation, DoHC;
   c. Head of Project Strategy Implementation, DoHC;
   d. Director of Personnel Section, DoHC;
   e. Chief Nurse, DoHC;
   f. Chief Medical Officer, DoHC;
   g. Principal Officer responsible for Nursing Policy Division, DoHC;
   h. Chief Pharmacist, DoHC;
   i. Principal Officer responsible for National Task Force on Medical Staffing, DoHC.

   n = 9

2) **Service Managers** – This category can be divided into two sub-groups:
   a. **Group 1 –** A limited group of key **targeted individuals with overall accountability** for the implementation of policy, the reform of the services and the delivery of services. A purposive sampling approach was adopted here aimed at ensuring

participation by the key most senior personnel involved in the management of the health services –

i. Chief Executive of HSE;
ii. Head of Change Management Team within HSE;
iii. Two Members of Board of HSE (Nurse Education and Author of Brennan Report (Government of Ireland, 2003);
iv. National Directors of HSE (National Hospitals Office (NHO), Primary Community and Continuing Care (PCCC) and Human Resources (HR)) (3)
v. Director of Health Boards Executive (HeBE);
vi. Health Board Chief Executives (11);
vii. Chief Executives of Major Academic Teaching Hospitals (12)
viii. Directors of Public Health (2).

The total for this group amounted to 33

b. **Group 2 –** A wider group of **service managers with responsibility for the delivery of services** in specific geographic areas and care settings selected randomly from a stratified list. Institutions for inclusion on this stratified list included representatives of acute and primary care settings where there is a significant nursing component. Out of a total population of approximately 360 for this category, a stratified random sample of 10 was chosen.

n = 43 – i.e. the combined total for group 1 and 2.

3) Medical Consultants – Out of a total population of 1,731 Consultants in the country, the research concentrated on those Consultants who were members of the National Taskforce on Medical Staffing and in clinical areas with nursing relevance.

n = 10

4) **Educators –** It is possible to divide this category into three, each of which has historically developed in very different ways and reflects a different culture and professional emphasis –

a. **Group 1 –** Professors of Nursing and/or Midwifery and Heads of Schools of Nursing and Midwifery in Universities. The specific characteristics of this group is that not alone are they responsible for the delivery of essential services in the areas of pre-registration education, post-registration academic education and CPD, but they are also expected to take a lead in the promotion and development of research in nursing and midwifery. The size of this population is 7, however, in two institutions the role of Professor of Nursing and Head of School has been divided, where, as a general rule, the former is responsible for the development of research and the latter is responsible for the delivery of educational services. In both these cases it would be important to interview each individual. Therefore the population and sample size in this case is 9.

b. **Group 2 –** Heads of Schools of Nursing in the Institutes of Technology, where the emphasis is on the delivery of pre and post-registration educational services. The total population size for this group is 7, all of whom were targeted for inclusion in the research.

c. **Group 3 –** Directors of the newly formed Centres for Nurse Education, located in the major teaching hospitals and with a specific role in the area of CPD and development of links between education and clinical practice. The total population size for this group is 19, 10 of whom were randomly chosen for inclusion in the research. Centres of Midwifery Education had not been established at the time of this study.

n = 26

5) **Nursing and Midwifery Planning and Development Units (NMPDUs) –** There are 8 Directors of these Units in the country. All of them were included in the research.
n = 8

6) **Directors of Nursing and Midwifery –** The total population size of this category is 268. The population was divided into strata. The criteria for stratification and weighting was by Band, Geographic location and area of service delivery (i.e. acute care and primary care).A random weighted stratified sample of 40 was chosen form this population to be included in the primary research.
n = 40

Categories 1 to 6 constituted the principal group involved in the determination of the future role for nursing and midwifery in the Health Services. For that reason they were main target for primary research. For the additional categories (7 to 10), there existed a number of secondary research resources that report on primary research, recently conducted, that could serve as a basis for analysis of the issues from the perspective of these categories.

For categories 1 to 4, and for category 5, Group 1, the principal instrument for data collection was semi-structured interviews. For category 5 Groups 2 and 3, and for category 6, focus groups were used. For categories 7 to 10 secondary research sources were used.

Thus, a total of 79 semi-structured interviews were planned as part of this research, broken down as follows –

1) Policy Makers – 9
2) Service Managers – 43
3) Medical Consultants – 10
4) Educators, Group 1 – 9
5) Directors of NMPDUs – 8

In addition, 9 focus groups were planned with 57 individuals, broken down as follows –

1) Directors of Nursing and Midwifery – 40
2) Directors of Centres of Nurse Education – 10
3) Heads of Schools of Nursing and Midwifery in the Institutes of Technology – 7

The semi-structured interviews were conducted face-to-face. A more detailed description of the instruments used and the approach adopted is provided in section 4.6, “Research Instruments”.

The following tables (4.2 to 4.5) summarise the information concerning planned population, samples and selected data collection methods for each of the target categories:

Table 4.2 – Summary of Planned Population, Samples and Data Collection Methods – Policy Makers

Population	**Planned**	**Collection Method / Instrument**
Relevant senior civil servants in the DoHC; Chief Nurse; Chief Medical Officer – Population = 9	9 targeted individuals – (1) Secretary General, (2) Assistant Secretary responsible for Strategy Implementation, (3) Head of Project Strategy Implementation, (4) Director of Personnel Section, (5) Chief Nurse (6) Chief Medical Officer (7) Principal Officer responsible for Nursing Policy Division (8) Chief Pharmacist (9) Principal Officer responsible for National Task Force on Medical Staffing n = 9	Semi-structured interview

Table 4.3 – Summary of Planned Population, Samples and Data Collection Methods – Service Managers and Medical Consultants

Population	Planned	Collection Method / Instrument
Service Managers		
Interim Management Team for HSE; Board of HSE; Chief Executive of HSE; National Directors of HSE; Chief Executive of HEBE; Chief Executives of Health Boards; Programme Managers for Community Care Services, General Hospital Services and Special Hospital Services in Health Boards; Chief Executives / General Managers of Health Board healthcare institutions; Chief Executives of Public Voluntary Hospitals and Private Hospitals. Population = 360 (ca.)	Group 1 – Chief Executive of HSE (1); Head of Change Management Team within HSE (1); Members of Board of HSE (Nurse Representative and Author of Brennan Report) (2); National Directors (Hospitals Office, PCCC and HR) (3) Director of HeBE (1) Health Board Chief Executives (11); Chief Executives of Major Academic Teaching Hospitals (12) Directors of Public Health (2) n = 33 Group 2 – Other Service Managers 10 – random stratified sample n = 10 sub total n – 43	Group 1 – Semi-structured interview Group 2 – Semi-structured interviews
Medical Consultants		
Consultants (Population = 1731) – Anaesthesia (265) Emergency Medicine (31) Intensive Care (1) Medicine (316) Obstetrics and Gynaecology (93) Paediatrics (96) Pathology (159) Psychiatry (276) Radiology (163) Surgery (331)	Consultants who were members of the National Taskforce on Medical Staffing and in clinical areas with nursing relevance n = 10	Semi-structured interviews

Table 4.4 – Summary of Planned Population, Samples and Data Collection Methods – Educators and Directors of Nursing and Midwifery and Directors of NMPDUs

Population	**Planned**	**Collection Method / Instrument**
Educators		
Heads of Nursing Schools and Professors in Third Level Institutions (Population = 16); Directors of Centres of Nurse Education (19)	Group 1 – Heads of School / Professors of Nursing in Universities n = 9 Group 2 – Heads of School in Institutes of Technology n = 7 Group 3 - Directors of Centres for Nurse Education n = 10 sub total n = 26	Semi-structured interviews Focus Groups Focus Groups
Directors of Nursing and Midwifery		
Population = 269 According to band and institutions / community settings	Stratified random sample, taking account of Band and Geographic location / Health Board n = 40	Focus Groups
Directors of NMPDUs		
Population = 8	All. n = 8	Semi-structured interviews

Table 4.5 – Summary of Planned Population, Samples and Data Collection Methods – Assistant Directors of Nursing and Midwifery, Clinical Nurse / Midwife Managers, CNS/CMS, ANP/AMP, Staff Nurses / Midwives

Population	Planned	Collection Method / Instrument
Assistant Directors of Nursing and Midwifery		
Information on population size to be defined	No primary research.	Secondary research sources from National Council – especially Agenda for Future Professional Development of Nursing and Midwifery (National Council, 2003a))
Clinical Nurse / Midwife Managers		
Includes all CNM 1, 2 and 3. Includes also Assistant Directors of Nursing, and Nursing Practice Development Coordinators. Information on population size to be defined	No primary research.	Secondary research sources from National Council – (National Council, 2003a)
CNS/CMS and ANP/AMP		
ANPs (Population = 6); Clinical Nurse / Midwife Specialists (Population = 1,514)	No primary research	Secondary research sources from National Council – especially An Evaluation of the Effectiveness of the Role of CNS/CMS in Ireland (National Council, 2004c); A Preliminary Evaluation of the role of the Advanced Nurse Practitioner (National Council, 2005e)
Staff Nurses / Midwives		
All nurses and midwives employed in public sector. Includes staff nurses, midwives, public health nurses. Population = 33,474 (DoHC annual census 2000)	No primary research	Secondary research sources from National Council – especially An Examination of the Professional Development Needs of Staff Nurses and Midwives in Ireland (National Council, 2004d); Agenda for the Future Professional Development of Public Health Nursing (National Council, 2005a)

4.6 Gaining Access and Scheduling Interviews and Focus Groups

The process of gaining access to participants was planned as follows:

A letter of introduction requesting their participation was sent to potential participants in both semi-structured interviews (Appendix 15) and focus groups (Appendix 16). This letter was accompanied by an information sheet (Appendix 17), which contained a brief description of the research and how the interview or focus group would be conducted. The information sheet also mentioned that the interview or focus group would be recorded, that participation was totally voluntary and that the identity of individual contributors to the research would not be revealed. The letter also included a copy of the interview schedule or focus group schedule (Appendix 18) to enable participants to see what kinds of questions they would be asked.

The letter indicated that the researcher would follow up with a telephone call to check availability to participate and to arrange a suitable date. As the participants involved in the interviews and focus groups were all senior members of staff within their organisations, the scheduling of the interviews and focus groups had to be done weeks in advance in most cases.

The interviews were, for the most part, held in the interviewees' office and were conducted on dates and times that suited the interviewees. Sometimes, it suited interviewees to be interviewed in the researcher's office (in the National Council for the Professional Development of Nursing and Midwifery) because it was more convenient for them. The general principle applied was that location was determined according to what suited the interviewee.

The scheduling of the focus groups was done by negotiation with the participants regarding time and location, applying the principle of suiting participants in so far as it was possible. The locations for the focus groups

included rooms reserved for the purpose in hotels that were convenient for the participants, or in the premises of one of the participants (e.g. two were held in different CNEs).

Finally, once the interview or focus group had been completed, a letter of thanks was sent to each participant (Appendix 19)

4.7 Research Instruments

The principal research instruments used for the primary research in this study were face-to-face semi-structured interviews and focus groups.

In developing the interview schedule for the semi-structured interviews and the focus groups (Appendix 18), the guidelines provided by the Trent Focus Group were used (Mathers et al 1998; Robson, 2002). The same interview schedule was used for both the semi-structured interviews and the focus groups.

4.7.1 Guidelines for the Semi-structured Interviews

The following general guidelines applied to the preparation and conducting of the semi-structured interviews (Mathers et al, 1998; Robson, 2002):

The semi-structured interviews were conducted on a face-to-face basis due to the sensitive nature and complexity of the subject matter. Subject to prior permission of the respondent being secured, the interviews were tape-recorded. This significantly reduces the potential for error or bias to be introduced into the recording of responses.

Each respondent was contacted by letter (Appendices 15 and 16) and by phone to secure agreement and to agree on a convenient location and time. This letter included information on the purpose of the interview (Appendix 17) and the likely duration. Respondents were assured of the voluntary nature of their

participation and of the confidentiality of their responses. At the beginning of the interview, the respondent was asked to sign a consent form (Appendix 20).

Each interview was planned to last no longer than 60 minutes, with 15 minutes allowed for introduction and conclusion (giving an actual interview time of 45 minutes). At the end of the interview the respondent was given a contact telephone number should they wish to follow up on their comments or seek additional information on the progress of the research. If the respondent so required, a copy of the manuscript of the interview was made available to them.

The interviews consisted of a series of open questions relating to the 13 objectives of the research that had been identified. An integral part of the interview technique was ensuring that the respondent understood the purpose of the interview and was willing to cooperate. This required the clarification of questions, the correction of misunderstandings, the use of prompts, the probing of responses and following up on new ideas that emerged in the course of the interview.

Coding of responses was started only when all the interviews were completed, when comparison and cross-checking with other interviews was possible. Given the exploratory nature of the research and the large amount of attitudinal information to be collected on such a large scale, there was no list of pre-defined codes. This contributed to the minimalisation of any bias in interpretation because there was no question of trying to fit responses to a pre-defined set of codes (Mathers et al, 1998). A typed script of the recorded interview was produced and used as the basis for the determination of analysis codes.

An interview schedule was designed that outlined the questions to be asked, the probing to be done and the cues and prompts to be used. The following general guidelines applied to the interview schedule:

The questions related directly to the objectives of the research and were predominantly open in nature. Leading questions were avoided.

The questions focused on eliciting the experiences, opinions and beliefs of the respondent on the subject matter. It was sometimes necessary to probe to determine whether the responses were based on first hand experience, personal knowledge, or third party sources. It was important that the responses were able to be classified according to whether they represented the individual opinion of the respondent or whether they were a reporting of fact. The use of prompts and probing determined whether the level of knowledge and understanding of the respondent was such as to merit more in-depth exploration of a particular topic, or whether it was more worthwhile to pass on to a subject about which they were more informed.

The interviews were conducted in a relaxed and conversational manner, designed to encourage the respondents to express themselves. During the course of the interview, particular attention was paid to the phrasing of the questions, the emphasis expressed through the tone of voice and the use of body language by the interviewer and the use of good listening skills (knowing when to listen and when to prompt).

Every effort was made to avoid interviewer bias by bringing the personal perspectives of the interviewer into the interview. The avoidance of this kind of bias was enhanced by the continuous use of open questions, appropriate prompts and by good listening skills. However, in interviews with senior personnel, it was considered that it was sometimes necessary to build up empathy by entering into a discussion that required the expression of some personal opinions.

The overall flow of the interview was ensured by the use of techniques such as not interrupting, following up on leads, asking about both sides of an issue and using reflective comments which gave the respondent permission to continue to discuss and consider a particular topic. This also included allowing for meaningful silences.

4.7.2 Guidelines for the Focus Groups

Many of the guidelines for semi-structured interviews also applied to the focus groups. The following specific guidelines, however, were also used –

Participation in the focus groups was determined using a random weighted stratified sampling criteria as described in section 4.5 above. Each focus group consisted of no more than 12 participants.

Each focus group was conducted by the researcher in the role of moderator of the discussion. A note-taker was also in attendance. The note-taker commented in writing on the general atmosphere of the session and made any other observations of interest. She was also responsible for ensuring that the manuscript reflected faithfully the content of the discussion.

The discussions were recorded, with prior permission of the participants. Participants' anonymity was assured. Each discussion lasted approximately one hour. The discussion was conducted with the aid of a question guide prepared in advance (Appendix 18). Probing questions were used to follow up on contributions that required further clarification.

The taped discussions were transcribed and used as a basis for coding. The coding facilitated the analysis of the content and the identification of themes raised within and across the focus groups. The outcome of this process was cross-referenced with the outcomes of the semi-structured interviews.

4.8 Data Analysis Techniques

The principal steps in the data analysis included the following:

The taped interviews and focus group discussions were transcribed, producing a verbatim hard copy of the respondents' contributions.

Preliminary computer analysis of the data, including coding of the material transcribed, was undertaken using a proprietary software package (Ethnograph v5.08) designed for qualitative data analysis (Qualis Research Associates,

2001). A description of the practical experience of using the software for coding and analysis of data is available in section 4.10 of this chapter.

Particular attention was paid to issues raised in all or most of the focus group discussions and the issues that were most discussed. This resulted in the compilation of a list of the most frequently assigned codes. The importance of reflection in data analysis is highlighted in section 4.10 of this chapter, along with an account of the experience of doing this in this research.

The intensity of the discussion and views expressed on the issues raised was analysed based on the list of most frequent codes. A full analysis of the frequency of occurrence of codes is provided in section 4.10 of this chapter.

In addition to computer-assisted analysis, further manual content analysis was undertaken because of the complex nature of the data and of the concepts being researched (see section 4.10). This is an integral part of the iterative nature of the reflection required on the data and is described in section 4.10 in more detail.

The analysis of content and the coding of the data facilitated the identification of themes within and across focus groups and individual interviews. This provided the basis for the development of a thematic framework, showing the interrelationship between emerging themes. The themes were further subdivided into categories, and within each of the categories individual codes were identified. Detailed analysis of the experience of doing this is provided in section 4.10.3 of this chapter.

4.9 Ethical Issues

4.9.1 Research Approval

Approval for the research was granted by the Ethics Committee of the Faculty of Health Sciences, Trinity College, Dublin, and the standards required by the Committee have been incorporated into the design of the methodology. In order

to gain approval, the researcher was required to provide the Ethics Committee with a detailed description of the research to be conducted and of the methodology to be used. The *Research Ethics Application Form* (Appendix 21) required detailed descriptions of the way in which participants would be recruited, how the confidentiality and privacy of the participants would be guaranteed and how the consent of individual applicants would be gained. The researcher was also required to provide samples of the informed consent form (Appendix 20), the letter of invitation to participate (Appendices 15 and 16), and the information sheet for participants (Appendix 17).

In qualitative research there is an obligation on the researcher to be aware of sensitive issues and potential conflicts of interest between gaining insights into the subject of the research and maintaining and protecting the rights of the participants in the research (Arksey & Knight, 1999). This means that in pursuing the objectives of the research, it is important to proceed with sensitivity and respect for participants. In order to ensure that this happens, qualitative research needs to proceed within the framework of ethical guidelines (Tutty et al, 1996). These are in turn based on the key principle of justice, understood as an avoidance of exploitation and abuse of persons (Orb et al, 2001).

An ethical framework for qualitative research of the kind carried out in this study usually includes considerations for the personal safety of participants, informed consent, information on the purpose of the study and guaranteeing privacy and confidentiality (Singleton & Straits, 1999).

4.9.2 Personal Safety

The issue of personal safety involves ensuring that the physical safety of participants is guaranteed and also that they will not be subjected to any personal embarrassment, humiliation or other negative psychological experiences. This includes protecting their personal self esteem and avoiding asking questions that might prove threatening or embarrassing. It also involves

ensuring that nothing is reported that could be construed as an invasion of the privacy of the individual (Singleton & Straits, 1999).

4.9.3 Informed Consent

The issue of informed consent relates to the need to ensure that participants feel free to participate or decline to participate in the study. This has important legal and moral connotations. It requires that participants are provided with sufficient information to enable them to make an informed choice. It also requires of the researcher to gain written consent from the participant before engaging in the research (Singleton & Straits, 1999).

Providing the participant with sufficient information includes describing the purpose of the study, the nature of the involvement of any institution in the study and the identity and background of the researcher. It also requires the researcher to provide information on the nature and number of the questions that will be asked, the duration of the interview, whether the interview will be taped or not, the venue of the interview and how the data gathered will be used (Tutty et al, 1996). It is also recommended that the results of the study should be made available to participants (Nelson Hagemaster, 1992).

4.9.4 Privacy and Confidentiality

The issue of the right to privacy raises questions about when, where, to whom and to what extent attitudes, beliefs and behaviours are revealed (Singleton & Straits, 1999). It is also about the right of the participant to remain anonymous and to be reassured that a code of strict confidentiality will apply to any information, beliefs or attitudes that are recorded. This is something that presents difficulties in research such as this, given that the interviews and focus groups involve face-to-face meeting, and in the case of the focus groups, people other than the researcher are present and aware of the involvement of an individual (Berg, 1998). What is important, however, is to ensure that confidentiality is guaranteed in the research by taking every step necessary to ensure that the identity of individual participants is not possible to determine

from the results of the research. This involved maintaining research records in such a way as to ensure that identities were protected and writing up the results of the research in a manner that protected the identity of individual participants.

Another important dimension to the ethical conduct of a study of this nature is the question of relationship between the researcher and the participant. This can be particularly difficult when they are peers, colleagues or known to each other through reputation, as was the case in this research. This required a high degree of sensitivity on the part of the researcher not to use the existence of such a relationship to compromise the participant in any way. It was also necessary to give a great deal of thought to the formulation of the questions to be asked, to exercise a high level of self-awareness while conducting the interview or focus group and to use active listening skills. It also required the researcher to be careful not to become involved with the participants in a way that might compromise the objectivity of the research (e.g. by showing agreement or disagreement with a statement); this required the researcher to remain detached and objective.

4.10 Reflections on the Practical Application of the Methodology

4.10.1 Introduction

In applying the methodology described in previous sections of this chapter, a number of issues emerged that have a practical bearing on the way in which the research developed. This section provides a description of the adaptations to real life circumstances that are part and parcel of a researcher's experience. In particular, the outcome of the sampling and targeting exercise for both the interviews and focus groups (4.10.2); the steps taken towards defining the themes, categories and codes and the results of that process (4.10.3); a description of measures taken to ensure the validity and reliability of the coding and data analysis exercise (4.10.4); a description of some of the measures that were taken to ensure that the ethical framework of the research described in

4.9 was respected and adhered to (4.10.5). The chapter will conclude with some reflections on the data analysis process by way of introduction to the chapters that follow on the results of the research. This will include some reflections on the scope, extent and significance of the research undertaken, the issue of saturation, the challenge of dealing with such a large amount of data and, finally, the question of personal involvement of the researcher in the process.

4.10.2 Population and samples

In section 3.5 of this chapter, details were provided on the planned numbers of participants for each of the categories of participants in both the semi-structured interviews and the focus groups. The rationale for the sampling approach adopted was based principally on the desire to ensure that all of the key stakeholders within the health services would be involved. This required a purposive approach in some cases to the sampling exercise. It was also important to introduce some stratification and weighting considerations into some of the categories (e.g. Service Managers in group 2 and Directors of Nursing and Midwifery) to ensure that different geographic and institutional settings would be represented in the research. The one key group that was missing from the stakeholders group was that of patient representatives. In most of the secondary research material used, patient representation was present. Patient representatives should be included in any future research.

The actual numbers achieved for each category can be summarised as follows:

In the case of the category policy makers, the targeted number of participants was 9 and the actual number of participants was 10. All of the targeted members of this sample group were interviewed. In the case of one of the targets (Secretary General of the DoHC) there was a change of personnel half way through the research and it was felt appropriate to interview the new holder of the post as well for completeness. This resulted in one addition to this sample group.

In the case of category service managers, the target was 43 and the actual number of participants was 35. The period during which the research was carried out was a very dynamic one for the services. It coincided with the creation of the Health Service Executive in January 2005 and the subsequent changes in personnel and roles. This made it a very difficult time to secure the commitment of individuals to participate in the research. Uncertainty about structures and roles coupled with the natural stress associated with a period of dramatic change militated against a simple recruitment process for willing participants. Three Masters of maternity hospitals could have been included in this group, as they could be described as service managers or medical consultants; they were actually included in the group of medical consultants.

In the case of the category 'medical consultants', the targeted number of 10 participants was exceeded, as 11 were actually interviewed. The original intention was to interview the medical consultants with relevant clinical backgrounds who were also members of the National Taskforce on Medical Staffing (DoHC, 2003c). Of the 10 targeted, 6 were interviewed as part of this category. In order to achieve the target sample, it was decided to target other medical consultants in disciplines of great relevance to nursing. These included: Maternity (3), Gerontology (1) and Emergency (1), bringing the total number of interviewees to 11. As mentioned above, in the case of the Maternity medical consultants, as Masters of their hospitals, they could also have been included as service managers. For the purposes of analysis however, they have been included in the sample group medical consultants. In addition, one of the medical consultants interviewed also fulfilled a role in the Regulatory Body for medicine. Regulatory bodies had not been included in the original sampling exercise. Following discussion with my research supervisor and consideration of the importance of this function, it was decided to add the category Regulatory Body to the population sampling exercise. For that reason, one of the consultants, for the purposes of analysis will not be included in the category medical consultants, but in the category Regulatory Body. Therefore, for the purposes of analysis, the number of members of the category medical consultants that were actually interviewed reduced from 11 to 10, which was the original target number. The additional medical consultant is then added to

the category Regulatory Body. This category includes the Regulatory Bodies for medicine and for nursing and includes therefore 2 participants.

In the case of the category educators, all of the targeted number of interviewees were actually interviewed.

In the case of the category Nursing and Midwifery Planning and Development Units, all of the targeted members of this sample group were interviewed (8).

During the period of the research, there was a great deal of industrial relations unrest within nursing and midwifery. This culminated in the industrial dispute that took place from 2nd April 2007 and lasted for 7 weeks. The public discussions that took place at the time highlighted the important role that Trade Unions played in the professions of nursing and midwifery. As the interviews progressed, it became apparent across all the categories of the interviewees that Trade Unions were an important factor and should therefore be included as part of the research. This change was discussed and agreed with my supervisor. A total of 2 interviews were carried out under this category.

With regard to the focus groups, for the category Directors of Nursing and Midwifery, 30 out of the targeted 40 participated. Two focus groups were held for Directors of Nursing and Midwifery in Bands 1 and 2 Hospitals, with a total of 11 participants; two focus groups were held for Directors of Nursing and Midwifery in Bands 3 and 4, with a total of 11 participants; two focus groups for Directors of Public Health, with a total of 8 participants. While the target sample of 40 was not achieved, it was deemed sufficient for the purposes of the research. In discussions with my supervisor, it was agreed that it was likely that saturation of opinion from this group had been achieved.

In the case of the category Directors of Centres for Nurse Education, 9 out of the target of 10 actually participated. This was spread over two focus groups in different locations and at different times.

In the case of the category Heads of School of Nursing and Midwifery in Institutes of Technology, it was decided not to proceed with focus groups for this category. Having completed the 76 semi-structured interviews and the focus groups with the other categories, it was decided, after discussion with the research supervisor, that in all likelihood saturation point had been reached on the data and information that was needed for the purposes of the research.[10] Nevertheless, in order to ensure that input from this important group was guaranteed, one face-to-face interview with one representative of this group was conducted. This brought the total number of semi-structured interviews to 77.

Table 4.6 – Summary of Numbers Participating in Interviews

Category	Target	Actual
Policy Makers	9	10
Service Managers	43	35
Medical Consultants	10	10
Educators	9	10
Nursing and Midwifery Planning and Development Units	8	8
Trade Unions	0	2
Regulatory Bodies	0	2
Total	**79**	**77**

Table 4.7 – Summary of Numbers Participating in Focus Groups

Category	Target	Actual
Directors of Nursing and Midwifery	40	30
Directors of Centres of Nurse Education	10	9
Heads of School of Nursing and Midwifery in Institutes of Technology	7	0
Total	**57**	**39**

The final outcome therefore was: 77 semi-structured interviews were completed (against a target of 79) and 39 participants in focus groups (against a target of 57). The total target number for participation in the research was 136 (79 plus

[10] A detailed discussion on saturation of data is provided in section 4.6

57). The actual numbers achieved were 116 (77 plus 39). The actual participation level therefore represents 87.2% of the target level of participation. This was deemed by the researcher and the research supervisor as sufficient for the purpose of the research, as data saturation appeared to have been reached.

No pilot testing of the interview schedule was conducted for this research. This was deemed unnecessary by the researcher and the research supervisor because of the very focused nature of the questions involved and the nature of the semi-structured interview process itself. The primary research was driven by the objectives of the research, which provided the basis on which the interview schedule and the schedule for the focus groups were developed.

4.10.3 Themes, Categories and Codes

The thirteen objectives identified for the research (4.2) formed the basis for the formulation of the questions that were used in the semi-structured interviews and the focus groups (4.7). As each of the 77 interviews and each of the focus groups were completed, the text was transcribed and imported into Ethnograph, a specialist software package designed for the analysis of qualitative data using a proprietary coding system (Qualis Research Associates, 2001). The version of the software package used was Ethnograph v5.08.

The coding system used in Ethnograph facilitates the identification of sections of text that contain information, views, opinions of relevance to the questions asked (and consequently of relevance to the objectives of the research). This enables the researcher to collate all similar sections of text under a single code and tabulate the number of incidences / occurrences of that code throughout all of the interviews or focus groups.

In order for Ethnograph to work it is important to have a clear understanding of what information is sought through the interviews. During face-to-face interviews and focus groups, many comments are made that may be very

interesting in themselves but that are not relevant to the objectives of the research. The system of coding is an important way of ensuring that the information collated is directly relevant to the questions being asked.

The process of defining and using codes is based on an initial intensive phase of familiarisation with the data in the transcriptions. This involves intensive reading and reflection and the use of pencilled annotations in the margins to record impressions and ideas on possible codes. It took a number of iterations of this process, over a number of transcriptions, before a final approach to the coding was arrived at. This process also involved a considerable amount of discussion and testing with my research supervisor. In the end, it was decided to work on the basis of an agreed number of themes, under which a number of categories could be defined and for each of the categories an individual code could be arrived at and defined.

Having familiarised myself thoroughly with the material in the transcribed texts and keeping in mind the objectives of the research, four key themes emerged. Each of these themes was assigned a two digit code. These were:

- The Future of the Health Services – FH;
- The Changing Role for Nurses and Midwives in the Health Services – RC;
- New Skills Required of Nurses and Midwives – SK;
- Changes in Education for Nurses and Midwives – ED.

Each of the themes was then subdivided into a number of categories aimed at providing more detail about the theme in question. Each of the categories was assigned a two digit code. Categories were then subdivided into individual codes, each of which was allocated a two digit code.

As a result, each code is made up of six letters – the first two letters indicate the Theme (e.g. FH = Future of Health Services); the second two letters indicate the Category (e.g. SP = Systems Pressure); the third two letters indicate the

Code (e.g. AE = A&E). This generates the code FHSPAE. There are 4 themes in all. There are between 4 and 11 categories per theme. The total number of codes for all themes and categories is 90.

Appendix 22 contains a table summarising the totality of themes, categories and codes used throughout the data analysis.

The detailed results of the analysis of these codes and of the text references they refer to is contained in chapters 5, 6 and 7. Chapter 5 contains a detailed analysis of all of the theme, categories and codes that refer to the Future of the Health Services in Ireland. Chapter 6 contains a detailed analysis of all of the theme, categories and codes that refer to the Changing Role of Nursing and Midwifery in Ireland. Chapter 7 contains a detailed analysis of the themes, categories and codes that refer to Building Skills and Competencies in Nursing and Midwifery in Ireland. The latter is a combination of the themes for Educational Changes (ED) and Skills (SK).

The code book generated by Ethnograph is built on a family tree principle, with the themes being the mother codes and the categories and individual codes the daughter and granddaughter codes respectively. A full presentation of the entire code book, including the entire family tree and definitions of each of the individual codes used is provided in Appendix 23.

The coding of each individual transcript was done using the 6 digit codes defined in the code book. A sample extract from a transcript of an interview is provided in Appendix 24. A sample extract from a coded interview is provided in appendix 25

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4.10.4 Validity and Reliability

4.10.4.1 A review of the theory

Validity in qualitative research is defined as the extent to which the data are plausible, credible and trustworthy; and thus can be defended when challenged (Maxwell, 1992).

Surridge (2007) asks 'What makes a good qualitative study? How would you judge it?' She replies that it comes down to questions of language and defensiveness, methods of assessment, reflexivity (self awareness, reflection and impact), and audit trail.

Maxwell (1992) identified three types of validity in qualitative research. *Descriptive Validity* refers to the accuracy of what is reported by the researcher (the events, the objects, the behaviours, the setting, etc). For example, that what is reported actually happened and that what was heard or observed is accurately reported. *Interpretive Validity* refers to the accuracy in interpreting what is going on in the minds of the participant and the degree to which the participant's views, thoughts, feelings, intentions and experiences are accurately understood by the researcher. *Theoretical Validity* refers to the extent to which the theoretical explanation developed fits the data and therefore is credible and defensible.

Johnson (1997) and Benz & Newman (1998) identify a number of strategies for addressing the validity issue, some of which are relevant to this study and some are not (see also Aguinaldo, 2004 and Myers, 2000):

1) *Extended fieldwork or Prolonged Engagement On-Site – If possible qualitative researchers should collect data over an extended period of time* – This strategy was not appropriate for this study because I did not intend to conduct any phenomenological observations that would require extended fieldwork. Robson (2002) points to the dangers of 'going native' because of too close involvement with the subject of the research. In this case, the study is being done from within the group; therefore the benefits of prolonged engagement with the subject of the study are already there. What needed to be monitored was the danger of too close involvement. This was best done through a critical use of the some of the other strategies listed

here (see in particular, Reflexivity, Negative Case sampling, Peer Review, Triangulation).

2) *Low inference descriptors – Use descriptions phrased very close to the participants' accounts and researchers' field notes, e.g. verbatims (i.e. direct quotes) are a commonly used type of low inference descriptors* - This is an important technique that was used in this research, informing the approach to coding of the verbatim accounts of the interviews and focus group discussions. Robson (2002) points out the threat to validity posed by description and recommends for that reason the use of audio and or video tapes as a basis for ensuring fidelity to what was recorded. The chapters on presentation of results (chapters 5, 6 and 7) use direct quotes from the transcripts of the interviews and focus groups.

3) *Triangulation – Cross-checking information and conclusions*: This theme is covered by many authors, with slight variances in how they interpret and emphasise each aspect of it. The model used here is based principally on Maxwell (1992). Maxwell identifies four kinds of triangulation:

a. Data triangulation: uses multiple data sources to help understand a phenomenon
b. Method triangulation: use of multiple research methods to study a phenomenon
c. Investigator triangulation: use of multiple investigators (or researchers) when collecting and interpreting the data
d. Theory triangulation: use of multiple theories and perspectives to help interpret and explain the data

The approach adopted to triangulation in this study is described in section 4.10.4.2.

4) *Participant feedback: Discuss with the participants your interpretations and conclusions for verification and insight. Go back to those people and check the observations you made of them, i.e. is this what you meant? Is this what you did?* Robson (2002) denominates this approach 'Member Checking'. This approach was used once the coding of the texts transcribed from the

interviews and focus groups was completed. It involved providing 'Members' with a list of statements from the coded data and checking with them as to the plausibility of those statements (see 4.10.4.2 for a description of the outcome of this exercise).

5) *Peer review or Peer Debriefing: Discuss your interpretations and conclusions with other people, including a peer who is not interested but who could be critical and challenge your data and a peer who is interested in your study and can provide* insights *about your data* – This approach is built into the supervisory function provided in the University. Discussions were also held with relevant peers outside the university setting who had an interest in the findings and who could make constructive and critical contributions to the analysis.

6) *Negative case sampling - Examine cases that are contrary to your expectation, which help you confirm or disconfirm interpretations of the cases you are studying* – This approach provides an interesting opportunity to, as Robson (2002) puts it, 'play the devil's advocate' in the formulation of conclusions based on the research. The use of this technique is probably more relevant to grounded theory approaches to qualitative research.

7) *Reflexivity or Neutrality - You critically examine yourself to detect potential biases and inclinations that may affect your conclusions. Even though no data collected are 100% objective, the researcher should convince readers that a high level of objectivity has been maintained* – This is an integral part of the analysis process and was achieved by demonstrating and ensuring integrity in the interpretation of the data collected in the research. More detailed considerations of this important topic are provided in section 4.10.4.2

8) *Pattern matching - Try to predict results that form a pattern and then compare the extent to which the actual results agree with the predicted pattern* – This can include checking the meaning of outliers, using extreme cases, following up surprises and looking for negative evidence (or negative

case sampling) (Robson, 2002; Miles and Huberman, 1994). It was an important part of the discipline of ensuring objectivity when analysing the data collected in the research and reaching conclusions.

9) *Audit Trail - The researcher should have good documentation so that another researcher can easily replicate the research. More importantly, it allows someone to challenge or confirm the interpretation of the data made by the researcher* – A detailed audit trail was maintained throughout the research. This involves keeping a full record of the activities of the researcher while carrying out the study. The audit trail for this study includes:

a. All preparatory documentation, including research proposals, discussions and correspondence re proposals, correspondence with ethics committee, approval notifications.
b. All documentation related to recruitment of participants for primary research (letters of invitation, background information provided, signed consent forms) (Appendices 15, 16, 17 & 20)
c. Raw data (transcripts of interviews and focus groups, notes taken etc.)
d. A research diary kept on computer (including dates of appointments, meetings, notes taken, references gathered, additions to bibliography)
e. Details of the coding and data analysis (including hand marked transcripts, computer coded transcripts from Ethnograph, revised coded transcripts following on reflection and peer debriefing).
f. Record of member checking exercise, including original marked questionnaires from participants and letter to participants in member checking exercise (Appendix 26 and 27).

Good accounts of keeping an audit trail are provided by Robson (2002), and Lincoln and Guba (1985). Validity in the interpretation of data can be threatened by pre conceived frameworks. The ability to trace the steps

that led to a particular conclusion is an important part of demonstrating how you arrived there and strengthens the validity of the interpretation.

The adoption of the relevant strategies as described above helped considerably in ruling out threats to validity. However, as Robson (2002) points out, there is no foolproof way of *guaranteeing* validity. The observations made in section 4.3 of this chapter, on the theoretical framework for the study, particularly with reference to the epistemological paradigm that underpins the study, are particularly relevant.

4.10.4.2 A review of the practice

In practice, the three principal methods of ensuring validity and reliability of coding and data analysis were used. These were – Member Checking, Peer Debriefing and Triangulation. In addition, it was important that the use of the software package Ethnograph did not introduce any bias either into the approach to coding or to the subsequent analysis.

The following is a summary of the approach adopted under each of these headings.

Member Checking

A member checking exercise was conducted with two representatives of each of the categories of interviewees. This amounted to 10 individual interviewees, representatives of 5 categories of interviewee (3.5). Each of these 10 individuals received a verification questionnaire containing a number of statements on each of the themes of the research (Appendix 26). The statements were devised based on the data in the interview transcripts and were formulated in a positive way, reflecting what was deemed to be the view emanating from the majority of the interviews. Appendix 26 contains the full questionnaire as it was used, including the statements and the codes they refer to. The individual was asked to indicate the degree to which they agreed or disagreed with the statement in question, using a four box range (strongly

agree, agree, disagree, strongly disagree). Respondents were asked in an accompanying letter (Appendix 27) to mark their reaction to the statements based on whether they considered them to be plausible or not. The table in Appendix 26 replicates the verification questionnaire used for this purpose.

The table also serves as a useful introduction to the following chapters on presenting the results. The questionnaire contains a list of statements, each of which represents a code that was used for data analysis. The list of statements amounts to a definition of each of the codes used and can usefully be compared with the reproduction of the code book from Ethnograph reproduced in Appendix 23. The list is divided into three sections: the first contains statements that relate to the future of the health services in Ireland (to be presented in detail in chapter 5); the second contains statements that relate to the changing role for nursing and midwifery in Ireland (to be presented in detail in chapter 6); the third contains statements that relate to building skills and competencies in nursing and midwifery to meet future challenges (to be presented in detail in chapter 7).

The analysis of the findings of the member checking exercise confirmed that the coding of the data was generating outputs that were credible in the eyes of those who took part in the verification exercise. This outcome of the member checking exercise was deemed therefore to be satisfactory. The process and outcome was verified by my research supervisor. More detailed analysis of the outcome of this exercise will be provided in the results chapters (chapters 5, 6 and 7).

Peer Debriefing

The second method for ensuring validity and reliability of coding and data analysis was Peer Debriefing.

Three separate transcripts were provided to my research supervisor in a numbered but unencoded format. She proceeded to code the interviews independently. In doing this exercise, we agreed that she would check for

instances where the text in the transcript was relevant to the objectives of the research and the questions asked. Her coded interviews were then compared with those that that had already been coded and checked for consistency.

The result of this exercise produced a score of 85% consistency. This was deemed by both of us to be a significant and satisfactory score.

Triangulation

As discussed in section 4.4.1, the triangulation model used here is based principally on Maxwell (1992). Maxwell identifies four kinds of triangulation:

Data triangulation: uses multiple data sources to help understand a phenomenon – This is of relevance to this study. The case study included a detailed review of the issues involved using a number of different data sources (literature, policy documents, interviews, focus group discussions).

Method triangulation: use of multiple research methods to study a phenomenon – The methodology employed in this study included primary and secondary research methods, with a variety of primary research techniques being used (interviews and focus group discussions).

Investigator triangulation: use multiple investigators (or researchers) when collecting and interpreting the data – This approach was not suited to the methodology employed in this study. Recorders and observers were used in the focus groups, but it would not be appropriate to use different investigators. The use of Peer Debriefing (see above) and Member Checking (see above) however provided a degree of triangulation that is similar to what could be expected from *Investigator triangulation*.

Theory triangulation: use of multiple theories and perspectives to help interpret and explain the data –This approach was adopted when analysing and interpreting the data. Theories and perspectives from management disciplines, economic theories, public policy theories and analyses and other social sciences were incorporated into the analysis of the data (chapters 5, 6 and 7)

and in the preparation of a strategy for the professional development of nursing and midwifery (chapter 8).

Ethnograph

The choice of the software package to be used in this thesis was driven by a number of practical considerations. Most importantly it was felt that what was needed was a package that was capable of enabling the researcher to handle a large amount of text, generated through the interviews and focus groups, to assist in the coding exercise, to provide a solid platform for the analysis of the data.

The literature on available software packages and assessment of their relative strengths and weaknesses is full of warnings about the dangers inherent in becoming too driven by the technology. A good example of this is the National Science Foundation Handbook on Mixed Method Evaluations (Frechtling and Westat, 1997).

The National Science Foundation Handbook refers to the great proliferation of software packages that can be used to aid analysis of qualitative data and to the review of these packages that was carried out by Weitzman and Miles (1995), who grouped them into six types: word processors, word retrievers, text base managers, code-and-retrieve programs, code-based theory builders, and conceptual network builders. The Handbook points out that they all have strengths and weaknesses. Weitzman and Miles (1995) suggested that when selecting a given package, researchers should think about the amount, types, and sources of data to be analyzed and the types of analyses that will be performed.

The Handbook (and Weitzman and Miles, 1995) suggest that two caveats are in order. First, computer software packages for qualitative data analysis essentially aid in the manipulation of relevant segments of text. While helpful in marking, coding, and moving data segments more quickly and efficiently than can be done manually, the software cannot determine meaningful categories for coding and analysis or define salient themes or factors. In qualitative

analysis, as seen above, concepts must take precedence over mechanics: the analytic underpinnings of the procedures must still be supplied by the analyst. Software packages cannot and should not be used as a way of evading the hard intellectual labour of qualitative analysis. Second, since it takes time and resources to become adept in utilizing a given software package and learning its peculiarities, researchers may want to consider whether the scope of their project or their ongoing needs, truly warrant the investment.

The first of these warnings was one that I was particularly conscious of in the use of Ethnograph. The coding exercise was done principally based on a process of iterative reflection (as described in 4.3 above). The software package was a useful tool in this exercise. At no point did I feel that it intruded on my freedom to define codes for analysis.

The second warning was easily answered. It would not have been possible for me to manage such a large amount of data without the assistance of the software package and within the timeframe that I had set myself for the completion of this research.

An additional, more up to date source of comparative analysis on software packages available for this kind of work is available at the website of the University of Huddersfield (Taylor, 2005). The website contains the most recent (last updated 2004) comparative analysis of packages that I have been able to come across. It also contains a very useful comparative table that provides cross referenced information on a range of packages (Friese, 2004).

4.10.5 Ethical Conduct

In the implementation of the methodology for the primary research, particular care was taken to ensure that the ethical framework for the research described in section 4.9 was strictly adhered to.

Having achieved the consent of the participants to take part in the semi-structured interviews and focus groups, a digital recording of the session was made. The digital recording was then uploaded onto a laptop used for the purposes of the PhD and to which no other person has access. Access to the

laptop is via password (eight digit alphanumeric with variations in case). Once the voice data files had been uploaded the original file was deleted.

The recorder that was used for the purpose was a Sony MSV recorder. The system automatically allocates an eight digit number to each file as a unique identifier. The identifier consists of two digits for the year, two digits for the month, two digits for the day on which the recording took place, and finally two digits to indicate the sequence of recording on that day. Thus for example, the first recording that happened on the 22nd August 2007 would be named 07082200; the second recording that happened on that day would be named 07082201, and so on.

A transcript of the recording was then made on the same laptop and the participant(s) in each recording were allocated a four digit identification code. Thus for example, for the semi-structured interviews participants were named as I001 to I076, in order of participation. Participants in focus groups were not identified individually. The focus group transcript was give a four digit code FG01 to FG08, in order of participation. A sample transcript from an interview is provided in Appendix 24.

The transcripts were then uploaded to Ethnograph 5.08 for the purposes of data analysis. At that stage the original voice files were destroyed. This copper-fastens the process of protecting the anonymity of the participants.

Finally, at the data analysis process, and in particular in the use of extracts from the files in chapters 5, 6 and 7, any reference to places or events that might help to identify the participant were removed.

The research was therefore conducted to the highest standards of ethical probity and respect for the participants.

4.11 Conclusion and Introduction to the Data Analysis

The following chapters (chapters 5, 6 and 7) will be taken up with the presentation of the results that emerged from the interviews and focus groups. Before that exercise is begun, it is worthwhile making some comments by way of introduction on the following topics: The number of interviews and focus groups; the question of saturation of data; the scope and significance of the research; the question of personal involvement of the researcher in qualitative research.

The following categories of participants were identified for the primary research (3.2):

1) Policy Makers
2) Service Managers
3) Medical Consultants
4) Educators
5) Directors of the Nursing and Midwifery Planning and Development Units (NMPDUs)
6) Trade Unions
7) Regulatory Bodies
8) Participants in Focus Groups: Directors of Nursing and Midwifery (hospital and community), Directors of Centres of Nurse Education and Heads of Schools of Nursing and Midwifery in Institutes of Technology.

The first seven of these categories were to be participants in semi-structured, face-to-face interviews, of which 77 were completed. These interviews lasted on average about 45 minutes each. The size of the transcripts from each interview varied from 6 pages to 30, with the average size of transcript about 15. The sixth category included the Directors of Nursing and Midwifery from each of the main bands of Irish hospitals and the Directors of Public Health Nursing. The participants in this category were targeted for focus groups. A total of 39 individuals took part in these focus groups. These focus groups lasted on average 45 minutes and the transcript material for each session consisted of about 10 pages of A4 copy.

By the end of the research therefore the researcher had had in-depth contact with 116 individual participants and generated about 1500 pages of transcribed material.

What followed was a painstaking process of reading through the data with pencil in hand making comments in the margins. This was the beginning of the coding exercise. It took many reiterations of this to arrive at a system of coding that was satisfactory. The process of reading and re-reading, of reflecting and thinking was an essential part of coming to terms with the data and devising a coding system that would work. Once the coding system had been devised and a sample of transcribed texts had been coded, peer review techniques were used to validate the approach adopted.

With such a large amount of data and such a large number of individual participants, the question arises as to whether saturation had been reached well before the total target participation level had been reached. The question also arises as to the manageability of such a large amount of data, and the ability of the researcher to do justice to it, i.e. the ability to spend sufficient time reflecting on an iterative basis on the material in order to assimilate it, understand what the participants were intending to communicate, analyse it in a structured and unbiased way and reach meaningful conclusions.

With regard to the question of saturation, it is useful to define what is meant. Taylor (2006) defines saturation, or data saturation, as the situation where predictions and expectations based on existing data and categories are repeatedly confirmed by data from additional categories or cases. The additional categories or cases seem to contain no new ideas and they are then said to be saturated. The search for further appropriate instances seems futile and data collection can cease.

Having chosen to adopt a case study approach, and to consider nursing and midwifery as a “bounded system” (see section 4.3 above), the researcher felt it was important that all of the important determining factors within that system

would form part of the research. Thus, as a “bounded system”, nursing and midwifery operates within a public sector policy environment and within clearly defined service delivery structures and constraints. The manner in which nursing and midwifery operate within this policy environment and service delivery context is regulated by a statutory based self-regulatory regime. In addition, nursing and midwifery, as clinical professions, while independent professions in their own right, interact with the medical profession in a manner that is part of their very definition. This interaction is at the core of the profession. Finally, as a regulated profession, with standards of professional training and education required as a basis for entry, the professions cannot be considered adequately without detailed reference to the educational infrastructure on which they depend.

This analysis of the “bounded system” of nursing and midwifery places demands on the case study, qualitative researcher, interested in a comprehensive analysis of the role of the professions within the health services. The demands carry with them an inherent complexity of the environment and the amount of influences that the professions are subject to. It would not be possible to address the objectives of the research therefore without addressing in a serious manner members of each of the core categories that form part of the “bounded system”.

The numbers involved within the individual target categories were intended to be representative, not exhaustive. The individuals targeted were also intended to be capable of articulating at the highest level the strategic perspective that is required of the objectives of this research. It is probably the first time that such a comprehensive survey of the top people within each of the categories involved have been the subject of a single piece of research for nursing and midwifery. While it is fair to say that the Commission on Nursing (Government of Ireland, 1998) represented the most comprehensive overall review of the professions every conducted in Ireland to date, this research represented the most comprehensive survey of key decision influencers within the “bounded system” ever conducted.

With regard to the question of the large amount of data collected the following considerations are relevant.

The research began with a very clear focus, i.e. two clear aims translated into thirteen objectives (4.2). These objectives in turn translated themselves into 12 questions that formed the basis for the semi-structured interviews and the focus groups. These questions enabled the researcher to keep focused in analysing the vast amount of data that was generated. Repeated readings and meditations on the transcriptions, with the help of Ethnograph as a tool, helped to reduce the material to 4 key themes (4.3), within which a further 23 categories and 90 individual codes were identified. This provided the conceptual map with which to tackle the detailed analysis of the material, aided by the compass of the objectives of the research. It also meant that a lot of material that was of interest in itself was discarded as being of no relevance to the purpose of the research.

The researcher is satisfied therefore that saturation point had been reached with the research carried out. The researcher also believed that additional survey, interview or focus group work would not add any significant additional material to what had already been gathered and is satisfied, therefore, that the selection of the categories of interviewees and the numbers within those categories was justified.

Finally, on the question of personal involvement – the role of 'the researcher' in qualitative research, the following comments are of relevance.

The research that forms the basis of this work is in the tradition of Ethnography as defined by Creswell, i.e. the study of an intact cultural or social group based primarily on observations and a prolonged period of time spent by the researcher in the field. The ethnographer listens and records the voices of informants with the intent of generating a cultural portrait. (Creswell, 1998). The research itself has been carried out over a period of 4 years and generated a considerable amount of recorded data. It has also built on the researcher's 30 years of experience in the fields of nursing and midwifery, in clinical,

managerial, educational, regulatory and professional environments. It is obvious therefore that the researcher has been immersed in the field and spent a long time observing and recording.

The quality of the research, according to Surridge, is dependent to a large extent on the focus of the research question (Surridge, 2007). Some of the characteristics of good qualitative research questions include:

- It should be based on a legitimate need of inquiry
- It is not about causes
- It is not intended to prove something
- It focuses on perceptions, beliefs and understanding
- The researcher seeks to explore a range of ideas and views

Therefore for good qualitative research it is important that the question is appropriate to the qualitative approach and clearly formulated (Surridge, 2007).

Ethics is another important dimension in determining the quality of qualitative research (Surridge, 2007). This is because:

- By its nature, qualitative research deals with very sensitive issues
- It provides privileged access to participants and gatekeepers
- It involves and requires informed consent
- It requires a clear determination of where the research begins or ends
- It deals with the sensitive question of the anonymity and confidentiality of the participant. Can the participant be identified in reports by those who know them?
- It requires ethics committee approval in formal academic research settings.

For all of these reasons, the most important tool in qualitative research is the researcher. The researcher is the conduit between the research phenomenon, participants and the final product. How the researcher understands, interprets and represents the phenomenon is vital to the credibility of the work (Surridge, 2007).

As we approach the next three chapters on the results, therefore, the researcher is particularly aware of the importance of the researcher's perspective and relationship to the participants and to the phenomenon under study. In conducting the analysis and in exploring the findings, it is important that this is done while:

- Recognising the researcher's ideological and cultural perspective and making this explicit when arriving at conclusions.
- Exploring and accounting for the potential and actual impact of this perspective, including recognising the fact that, while conducting iterative reflection and acting as the principle conduit for the research, the researcher is an essential component of the "bounded system" being studied.
- Managing this interaction in ways such as reflective research journals before, during & after data collection, and through self interviews during analysis.
- Maintaining ongoing reflection on response to events & implications of changes.

These considerations represent the practical experiences of the researcher in working within the theoretical framework described in section 4.3 above.

Finally, it is the belief of the researcher that the analysis of the data to be presented in the following chapters will demonstrate that the qualitative research that underpins it was (Mason, 1996):

- Conducted systematically and rigorously
- Conducted strategically, yet in a flexible & contextual way
- Involved critical self-scrutiny and active reflexivity
- Produced social explanations to intellectual puzzles not mere descriptions
- Is generalisable and has wider resonance
- Can be seen as an ethical practice.

Chapter 5 – Results and Discussion 1 – The Future of Health Services in Ireland

5.1 Introduction

The interview schedule for the semi-structured interviews (Appendix 18) (4.7.1) devised as part of the methodology for the research, included a number of questions and probes to be used in the interviews. The first two of these questions referred to the changes in the socio-economic environment in which future health services in Ireland would be delivered, and the likely shape of the health services of the future. The questions and probes used are reproduced here for convenience:

Question 1 – What do you think will be the major contextual changes for the health services of the future?

Probes:
Changing socio-economic environment?
Future direction of policy?
Economic impacts?
Political impacts?
Social changes?
Other?

Question 2 – How would you describe the most likely future shape of the Irish health services?

Probes:
Separation of policy and executive functions?
Changes in organisational structures?
Changes in delivery mechanisms?
Acute vs. primary care?
Changes in accountability?
Changes in culture?
Changes in role?
Changes in size?

Changes in epidemiology?

Both these questions combined to provide a picture of the opinion of the interviewee on the future shape of the health services in Ireland – the first of the themes to be discussed (FH).

Within the general theme of the future of the health services, a number of categories were identified based on the comments of the interviewers. These categories included:

Socio-economic changes (SE)
Demographic changes (DE)
Separation of policy and executive functions (PE)
Organisational structures (OS)
Systems pressure (SP)
Accountability (AC)
Quality (QU)
Culture (CE)

These categories provide convenient headings under which we can analyse the individual codes that emerged under each of the categories. This chapter provides an analysis of the comments made by the interviewees under the theme and categories listed above.

5.2 Socio-economic Changes

The first category identified under the theme 'The Future of the Health Services in Ireland', was that of socio-economic change. A total of two codes were included under the category SE. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 5.1 Codes, Definitions, Frequencies – Socio-economic Changes

Code	Definition	Frequency
FHSEEX	The public will have increased levels of expectation regarding the quality and quantity of services provided.	26
FHSEWE	Future health services will be delivered in a society where increased wealth is the norm. Public expectations will increasingly establish a correlation between health and wealth.	11
	Total	37

A total of 37 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided[11].

There was universal agreement that socio-economic change was a significant factor affecting the future development of the health services. In the questionnaire sent as part of the member checking exercise (4.10) there was 100% agreement by the respondents. A remarkable feature of the feedback

[11] The quotations provided are taken from the texts of the interviews and focus groups. They contain reference to the category of interviewee involved in the semi-structured interviews (Policy, Service, Medical Consultant, Education, Director NMPDU, Trade Union, Regulation), or participant in the focus groups (Directors of Nursing and Midwifery), the number of the interview / focus group and the line numbers within the transcribed / coded text.

from the participants was the degree of awareness they demonstrated about socio-economic issues in Ireland today (see discussion in 2.2) and the consistency of opinion across all the categories of participants on the issues raised.

Interviewees commented that the future would see an increase in the levels of expectation amongst the public regarding the quality and quantity of services provided. A recurring theme throughout the interviews and focus groups was the extent of change that had taken place within Irish society in recent years. Consumers are seen to be more informed, more discerning and more demanding, with a high level of awareness of what constitutes value for money.

> *We have a very astute and smart consumer out there now who really knows the difference between a poor quality service and a good quality service and knows when they are getting value for money and when they are not. (Policy, I009, 55-60)*

Irish society has also changed in that there is much greater wealth available within the country. Wealth brings with it the expectation that things can be bought – Irish people expect to get more of what they want, sooner, and are intolerant of circumstances where they do not get what they expect / want.[12]

> *We are a much wealthier country and we have raised the bar of expectation hugely and we are utterly intolerant of not getting what we want immediately if not yesterday. (Medical Consultant, I060, 42-47)*

The changes in standards of living in Ireland is something that is frequently commented upon by those who have a memory of '*what things were like in the past'* and is also something that is noticed by people '*who were not living here in the past'* (*Education, I023, 48-55)* and who become conscious of how

[12] See detailed discussion of these issues contained in chapter 1.

frequently it is commented upon. It is something that is seen by interviewees and participants as likely to have an impact on future health service provision.

Future health services will be delivered in a society where increased wealth is the norm. Public expectations will increasingly establish a correlation between health and wealth. This is likely to mean that people will be intolerant of excessive queuing and having to wait for service provision, as one participant put it: *There won't be a tolerance for queues. The country is too rich and people too rich with too much money that they would demand an alternative (Service, I053, 20-24)*. This is likely to contribute towards the possibility of alternative sources of service provision being expected (e.g. private health services).

Medical consultants in particular comment on their perception of the way in which consumers of health services have changed and how the increase in wealth has contributed to an increase in levels of expectation regarding the quality and quantity of services being provided *(Medical Consultant, I035, 15-17)*.

This changes the nature of the relationship between consumers and service providers. Medical consultants comment on how a more informed, wealthier client will have a different attitude towards medical consultants. Whereas in the past, there may have been a perception that medical consultants wielded enormous power within the system, it is likely that a more informed consumer with more choices will be more discerning and look for medical consultants with the best skills for the service required.

> *Text 3*
> *People are going to come to us for our knowledge and our skills. That is why they are going to come. They are not going to come for our power anymore. (Medical Consultant, I021, 1589-1592)*

Finally, the expectations of the public regarding the quantity and quality of service provision will also place considerable pressure on service providers to

provide a new kind of leadership. Managing expectations in the light of increased costs of service provision, particularly the mounting costs of acute service provision, will require a new style of leadership *(Service, I043, 167-171)*.

5.3 Demographic and Epidemiological Changes

The second category identified under the theme 'The Future of the Health Services in Ireland' was demographic change (DE). A total of four codes were included under the category DE. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 5.2 Codes, Definitions, Frequencies – Demographic and Epidemiological Changes

Code	Definition	Frequency
FHDEAG	Future health services will have to contend with the fact that our population will live longer and the population will be made up of more elderly people who will require more services.	10
FHDEFA	Future health services will have to contend with changes in the structure and nature of family life.	11
FHDELI	Future health services will have to contend with changes in lifestyle and lifestyle related illnesses will become more prevalent.	18
FHDEME	The multiethnic nature of Irish society will provide a significant change of context for future health services.	30
	Total	69

A total of 69 segments were extracted from the interviews for this category, most of them (30) referring to the multi-ethnic nature of Irish society and the impact this will have on the provision of health services. There was a significant swell of opinion also in relation to the issue of lifestyle related changes that would impact on future health services (18).

Throughout the interviews frequent reference was made to what participants referred to as the ageing of the population. In general it was felt that this would become an issue of growing importance in the years to come. Related to this idea is the impact that increased longevity will have on the health services of the future:

> *And of course demography influences our epidemiology. The fact that we have people living longer – the issue of co-morbidity is a major one for the future. (Service, I052, 202-207)*

Ageing is seen as just one element of the significant demographic changes that are taking place within Irish society, which the participants acknowledged would bring new challenges for the caring professions of nursing and midwifery. Participants spoke about their concerns about the *"huge growth in population and ageing of the population and a shift from rural to urban living, and the immigration factor" (Service, I057, 15-23)*. Concern about the growth of the population is, as we have seen in 2.2, borne out by statistics, as Ireland has one of the fastest growing populations in Europe.

The demographic changes in society are also seen as having a significant impact on the relationships within families. The change in the relationships between dependant people and their families has knock on effects for the health services in general and for nursing and midwifery in particular[13]:

> *I mean if you look at the whole area of care of the elderly, and why has that become such a huge issue in recent years. I think that one of the main reasons that it has become such a huge issue is that families are no longer looking after their own, their old. So everybody is clamouring for care for their family. (Service, I067, 42-51)*

[13] See discussion on growth in labour force participation rates in 1.2, in particular rates for female participation.

It is a broad social issue, related to the question of where people live, where they work, how long they work, and the links / relationships that exists within communities. These factors change the nature of the demands that are placed on the health services:

> *And then there is the other impact, that is the impact for older people and where they live and who is going to be in proximity to them anymore when they are older simply because of the economic change. (Education, I072, 64-70)*

The implications of the 'new family frameworks' (see 2.2) have significant implications for the way in which we shape the primary care provisions of the future, the aspirations of which are frequently based on a traditional view of what the family framework is likely to be:

> *People cannot afford to provide the same family unit that they did maybe 30 years ago and some of the primary care aspirations we have are predicated on a traditional family environment. (Service, I043, 196-200)*

Economic prosperity and increased wealth within Irish society is seen by interviewees as being a major contributor to the increase in lifestyle-related issues for the health services. Many interviewees referred to changes in epidemiology related to lifestyle, and in particular increases in chronic conditions of obesity and diabetes, circulatory and cardiovascular conditions, related to the abuse of alcohol, drugs, unhealthy eating habits, sedentary lifestyles. Many interviewees expected these conditions to continue to grow and referred to them as 'affluence related' conditions. One interviewee also interestingly highlighted the fact that while we have and will increasingly have these 'affluence-related' issues, we also continue to have problems with 'poverty-related epidemiology':

> *This gives us the worst of all worlds – not really reducing dramatically the poverty related epidemiology and acquiring the worst of the affluence related stuff and I am thinking of alcohol and lifestyle related stuff and obesity and the fallout from obesity" (Service, I008, 162-178)*.

In one instance these lifestyle related changes were referred to as a 'selfish culture' of abuse and excess *(Trade Union, I068, 258-268)*.

By way of contrast however, many interviewees recognised the positive impact that the 'smoking ban' would have on future health services *(e.g. Director NMPDU, I009, 93-98)*.

This is further complicated by the increasingly multi-cultural nature of Irish society:

> *I think we are seeing huge social changes at present in relation to the fact that we have become a more multi-cultural society with less carers and that is certainly evident now in care of the elderly. We don't have the extended family. (Service, I047, 61-67)*

Multi-ethnicity and the challenges of a multi-cultural society featured largely in comments from interviewees. The health services need to respond to the many challenges that these changes present: "*In the last ten years Ireland has changed and it's going to change in terms of the population base, their origins, colour and indeed religious beliefs and health has to respond to those requirements. (Service, I006, 122-128)*.

Participants also commented on how maternity services have experienced an increase in the birth of non-Irish-national children in recent years *(e.g. Service, I010, 113-117).* Multi-ethnicity and multi-culturalism present significant communications challenges within the health services:

> *The way in which we communicate or don't communicate with people is an issue and we are now starting to develop pictograms and colours as a means of communicating with people who don't have English as their first language. But the cultural emphasis and differences need to be dealt with. (Service, I063, 12-23)*

Participants also spoke about the need to take account of the cultural background of the people who come to work in the health services: "*if we are to bring in Spanish nurses for example, do we need to try and have a Spanish environment in some of these hospitals, which is happening in the UK. (Service, I064, 417-431)*

The danger of introducing barriers within health service delivery is also a natural corollary of multi-cultural service deliverers and clients. Participants spoke about the fact that people from different cultural backgrounds who come to work in the health services in the future, will have some different needs:

> *There are language difficulties and the danger that a significant cohort of those will take up the lower paid jobs and the more menial jobs in the health service as well as elsewhere. We will have to find a way to be able to cope with the changes that will bring in terms of communication. I fear that it will actually bring in social barriers even more within health service delivery. (Medical consultant, I066, 39-55)*

The directors of nursing and midwifery who participated in the focus groups commented on the implications of social changes such as these for the education and preparation of nursing and midwifery staff and spoke of the need of *"having our staff trained up… to manage it" (Directors N&M, FG01)*

Because of the changes in population patterns, increased immigration and the development of a multi-ethnic society and the significant changes in lifestyle

patterns within Irish society, many interviewees recognised significant changes in epidemiology and changes already taking place in the kinds of conditions that are being treated within the health services. This includes for example, "*an increase in diseases such as AIDS, HIV, syphilis, and a recognition that Ireland still has one of the highest incidences of cancer and cardiac disease in Europe" (Education, I016, 250-255)*.

This also has implications for the skill sets and competencies of clinical staff involved in the health service as they will be coming across diseases and conditions that they may not have seen before such as for example "*conditions that are very common in tropical Africa, for example, sickle cell [anaemia]" (Education, I044, 516-524)*.

In keeping with trends throughout the OECD, there is a shift towards the consideration of population health issues and participants also raised the need for increased awareness, education and planning in that area *(e.g. Service, I052, 194-202)*

Finally, there is a very strong sense of significant change having already taken place and much more to come in the future:

> *There is no doubt that the culture of this country has changed significantly and that change is extremely rapid and … if we move forward ten years … we will see… even more of them.(Trade Union, I068, 244-253)*

5.4 Separation of Policy and Executive Functions

The third category to be discussed under the theme 'The Future of the Health Services in Ireland', was the separation of policy and executive functions (PE). A total of four codes were included under the category PE. The following table

provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 5.3 Codes, Definitions, Frequencies – Separation of Policy and Executive Functions

Code	Definition	Frequency
FHPEAD	There are advantages associated with the separation of policy and executive functions.	21
FHPEDI	There are disadvantages associated with the separation of policy and executive functions.	22
FHPECE	The separation of policy and executive functions will also be accompanied by a centralisation of executive functions in one body – the HSE.	40
FHPEDH	Future health services will be delivered in a context where the role of the Department of Health will change significantly – dedicated only to policy making.	34
	Total	117

A total of 117 segments emerged from the coding exercise for this category, a testament in itself to the range and diversity of views that interviewees held on the issues raised here. A probe was used in question 2 (5.1) on the separation of policy and executive functions[14], but no additional probes on this topic were used. The codes therefore represent the issues that emerged spontaneously from the interventions of the participants.

The participants in this research identified a fairly even distribution between the advantages and disadvantages of the separation of policy and executive functions (21 and 22). It emerged in the comments, however, that they (the participants) were unsure / uncertain about the nature of the changes that were envisaged. In particular it was not clear how the role of the DoHC would change and how this would develop. There was also a lack of clarity about the

[14] See discussion on this topic in 2.3.1.2.

relationship that should exist between the policy-making and the executive functions.[15]

A number of advantages were identified in the separation of policy and executive functions. Most participants agreed that the changes recommended by the *Prospectus Report "have the potential if they are differentiated adequately in terms of role and relationships to create an adequate tension to assure the aspirations of Quality and Fairness" (Service, I039, 58-67)*.The changes referred to included: the change in role of the DoHC to one of policy maker and monitor of implementation and performance; the creation of "*a single unitary or perhaps centralist delivery system such as the HSE";* and the creation of HIQA charged with development and implementation of initiatives in the areas of quality, information and standards *(Service, I039, 58-67)*.

Taking the politics out of health service delivery as a result of the abolition of the health boards in favour of one unitary system was also seen as positive. The centralisation of service delivery that results from the separation of policy and executive functions and the creation of a single deliverer is also seen as being of value in eliminating differences across the health services *(Policy, I002, 436-440)*.

An important corollary of the separation of policy and executive is that it should allow the DoHC to concentrate on the formulation of policy:

> *From the policy point of view, from the Department point of view, it allows a very clear opportunity and very clear space and a very clear set of circumstances within which far greater thought and far more time can be given to the preparation and formulation of policy. (Policy, I002, 372-377)*

[15] See detailed discussion of the issues raised in this chapter in chapter 1 (1.3)

Many participants, however, expressed the view that is not possible to achieve a complete separation of policy and executive functions, they depend on each other for their effectiveness and for their meaning. It was stated that *"it is very difficult to make informed policy if your finger is not very firmly on the pulse of operations (Policy, I005, 94-101)*. Participants in the research accordingly, recognised the need for those involved in service delivery to have an input into the formulation and preparation of policy. The HSE will want and need to be involved in the formulation of policy, otherwise it would be impossible for them to *"help to resolve the problems within the health service if they have no say in policy making" (Service, I001, 237-241).* Separating the DoHC from operations has the potential to lead to "*an ivory tower type existence" (Policy, I002, 445-449)* . This can result in local issues and needs not being considered adequately when it comes to formulating policy. So it is necessary for the DoHC to retain very close links with the executive functions if it is to formulate informed policy. It was perceived as being dependant on good links between both:

> *You cannot make policy without very significant inputs from the participation of executive functions and I think that the consequence of that is the relationship between the Department of Health and the Health Service Executive is very important to the success of it and if that relationship is not right it could create very significant problems in the system. (Service, I074, 47-63)*

Of central importance to the discussion of the separation of policy and executive functions is the definition in clear terms of the role of the DoHC relative to that of the HSE. Lack of clarity in this was evident in many of the interventions. One of the participants defined the role of the DoHC as follows:

> *To assist the Minister in the determination and making of policy to mobilise the resources from the Department of Finance to enable those policies to be put in place to put in place the regulatory and legal framework within which our health services can best work. And then on behalf of the*

Department of Health on behalf of the government to hold the HSE and the executive arm accountable for the delivery on the policy decision. (Policy, I002, 319-341)

This represents a very significant change in the role of the DoHC and in the relationship between the Minister for Health and the Health Services. It also represents a significant challenge for those involved in the management of the role of the DoHC. The system in Ireland *"contains an expectation that whoever happens to be minister … if something is going wrong even at detailed local level, 'why was that patient left on a trolley for three days?' he or she expects to get an answer from officials in the Department without necessarily having to go further than that. Also parliamentary questions, Dáil business ministerial representation is structured on that basis. (Policy, I005, 102…139)*.

The challenge of implementing these changes within the DoHC is enormous and will require a significant change in expectations, in culture and in the way business is conducted. Thus for example, the political system *"is going to have to accept that the Department of Health and Children and officials in the Department will no longer have the level of detailed knowledge and understanding that they had of individual services as they do at the moment" (Policy, I005, 152-227)*. The same participant went on to say: *"The establishment of the Health Service Executive is partly on the understanding that accountability for delivery of services will shift from the minister to the chief executive and his or her board of the Health Service Executive. That is a critical element of the new delivery system."* In practice this means that in the future if things go wrong with cancer services or childcare services, for example, it should be the chief executive and his or her staff in the HSE who should be answerable in the first instance *"and the minister holding them to account as opposed to the minister constantly being expected to stand up in the Dáil and explain why such and such a thing has gone wrong in relation to a particular hospital car park or whatever the issue happens to be" (Policy, I005, 152-227).* That, the participant concludes, is a very significant shift in accountability and *"it brings us back to culture because the culture of the system has to accept that change in accountability and who is responsible for what".*

Generally, participants in this research agreed that health service delivery arrangements to date have been overly disaggregated. A unitary service should provide more equal access and be better coordinated:

> *We are moving towards a very centralised structure and that can be a very good because it can give clarity in relation to services. It can push through equal access to services. It can help in terms of coordination (Service, I047, 110-116)*

Another important stated advantage of a single delivery structure is that it will provide an opportunity for increased emphasis on accountability. This is a topic that was very prominent throughout the whole of the research. A separate code exists on the topic of accountability (5.7) but it is important to note that changes in the relationship between policy and executive functions was also seen as contributing to a culture of accountability. Participants in this research were also of the opinion that this would *"make all of our lives hopefully more professional and more focused on the post or the purpose that we are employed for" (Regulation, I061, 96-101)*.

5.5 Organisational Structures

The fourth category discussed under the theme 'The Future of the Health Services in Ireland' was organisational structures (OS). A total of four codes were included under the category OS. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 5.4 Codes, Definitions, Frequencies – Organisational Structures

Code	Definition	Frequency
FHOSHO	There are many implications for hospitals in the new health services including the role of independent hospitals, the amalgamation of hospitals, the use of tertiary referral hospitals.	18

FHOSPA	Future health services will require the definition of new relationships between primary and acute services.	38
FHOSPC	Future health services will need to define the nature and extent of primary care service provision.	77
FHOSSD	Service development will be an important part of changes in organisational structures in future health services.	24
	Total	157

A total of 157 segments emerged from the coding exercise, with almost half of these (77) concentrating on the question of defining the nature and extent of primary care services, and an additional 38 focused on the question of the definition of relationships between primary and acute services. As will be seen from the texts chosen from the coded segments, this question of the relationship between primary services and the rest of the health services is a central theme when one considers the shape of the health services of the future. An understanding of these issues is important in the context of considering how the role of nurses and midwives (to be addressed in chapter 6) will change in the future.

The vision for hospitals of the future is one where they will concentrate on the major acute areas of intervention, requiring specialist and predominantly surgical intervention. Most other services can and should be provided in the community[16]. A movement in this direction has very obvious and serious implications for the roles of nurses and midwives. Most of their work will shift to community based settings and they could in fact provide a lead role in developing a wide range of community based services that have shifted from acute hospital settings: *"no point in nurses and doctors being left in hospitals to the degree that they presently are. They have got to follow where the patients are" (Service, I075, 246-274)*. The same participant commented on a range of practical situations where this could have a significant impact: *"we have hospitals in this country where we have a hundred thousand attendances at wharfarin clinics"*. The participant spoke about the implications of 100,000 people travelling to get their treatment when they should be given their

[16] See discussion on integration of services in chapter 1 (1.3.2).

treatment at home and went on to apply the same logic to diabetes and heart conditions that can be treated at home[17]. A number of other participants also expressed the view that large acute hospital centres should *"only be dealing with complex cases and surgical patients"*. Most of the services that are currently provided in hospitals can and should be moved out to the community. The participant concluded:

> *That has two major impacts; it has a huge impact on nursing in terms of you will not have that type of work going on within the acute hospital sector… it won't be justifiable for the cost of it to be provided there and then, secondly, that provides a huge opportunity for nurses to say that we will become the group who actually to a large degree take a lead role in how this will be provided at a community level (Service, I075, 246-274).*

The directors of nursing and midwifery who participated in the focus groups also expressed the view that there was an opportunity for nursing to provide some leadership in the area of relations between primary and acute care:

> *I think that if you are talking about the relationships between primary and acute services, I think that it is an essential area for the nurses to actually lead on. (Directors N&M, FG02)*

There remains however a significant challenge regarding the establishment of linkages within nursing and midwifery in primary and acute settings. One participant referred to the importance of engaging with practice nurses in the community, who work in GP practices and who, the participant believed, *"are very much outside the total care loop" (Service, I047, 245-256)*. The participant went on to comment that links between practice nurses and PHNs offered much opportunity but that they were in fact not as good as they should be.

[17] See note on Community Intervention Teams in chapter 1 (1.3.2)

A number of participants referred to the importance of the role of GPs as one that needs to be explored more in terms of the integration of services. One participant commented that they should be more closely integrated into the hospitals, allowing them to run clinics within the hospitals *(Service, I001,344-353)*.

Other participants pointed to instances where good working contacts had in fact been established with GPs in the area, particularly in the areas of midwifery and obstetrics services. Where this has happened, participants observed that positive changes had followed.

Good examples exist throughout the interviews of work that is ongoing in the area of integration of nursing services in cooperation with the NHO and the PCCC, looking at processes, integrating care pathways, caring case management and looking at the role particularly of the CNS (Service, I052, 141-149).

In view of the move towards a more integrated approach between acute hospitals and community care, a number of interviewees expressed concern about the creation of separate pillars within the HSE for the NHO and for the PCCC (see appendix 1 and 2). At a time when the trend in the services is towards a greater integration of services the structures put in place at the highest level do not mirror this. Participants referred to the problems faced by managers of acute tertiary hospitals with no input into what happens to long-stay beds in the surrounding area. If some of those beds are closed down because of lack of staff, the repercussions on the acute system are felt by the manager. Participants felt that integration of service management between primary and acute care should be reflected throughout the system, at a local community level and at the highest level within the HSE *(Service, I001, 269-316)*. The logical conclusion according to this participant would be for a single integrated management structure, involving the merger of NHO and PCCC.

Moving towards an integrated system also has implications for the relationships between existing hospitals within the system, and their relationships with

academic institutions. One of the participants referred to the creation of networks:

> *Changes in role – I think the ultimate aim is to have a single delivery system. I think there is a lot to be said for that. However, looking at voluntary hospitals and DATHs[18] hospitals … I feel that the hospitals have to look towards being able to share their services and inevitably there will be amalgamations and I think that is going to happen within the networks that are being formed[19] (Service, I001, 432-454)*

The role of hospitals is closely related to the question of epidemiology and the tension that exists for hospitals between their role as a provider of services in their local community and their role as tertiary referral centres with specialities that attract referrals from all over the country:

> *Epidemiology, by that you mean the patient population for the hospital and one of the big issues facing hospitals … is that it is both a community hospital for a local population a tertiary referral hospital with super national specialties, regional specialities, etc. So there is a constant tug between the two. (Service, I001, 455-509)*

Many references were made throughout the interviews to the Primary Care Strategy (DoHC, 2001c) and to the need to invest more in primary care. It was

[18] DATHs – Dublin Academic Teaching Hospitals; also referred to as MATHS – Major Academic Teaching Hospitals, when hospitals from outside Dublin (e.g. Galway, Cork) are included.

[19] Houston, M. (2007), *Irish Times Health Supplement, 7th August 2007: Two Major Dublin Hospitals Join Forces* – Article on the creation of the DAHC – Dublin Academic Health Care, involving a coming together of the Mater Hospital and St. Vincent's Hospital and the ceding by UCD of its medical school to the new group. The same article refers also to the creation of the TAMC – The Trinity Academic Medical Centre, an integrated medical centre involving St. James's Hospital, AMNCH Tallaght and Trinity College Dublin.

stated frequently that there is recognition of the need to invest more in this area but that there are difficult choices to be made because of the traditional approach of seeing investment in healthcare primarily in terms of capital spend on buildings and technology in acute services. One interviewee referred to the difference in the investment cycle between primary and acute services. The investment cycle in primary services can be as long as 40 years – the length of time it would take for a policy such as the smoking ban to take effect and show returns within the system. On the other hand the investment cycle in acute services is a fraction of that – the results of buying a machine can be seen almost immediately. The longer term investment in primary care is more sustainable and better in the long run but it requires a distinctive type of leadership to resist the pressure from the professions for the short term investment (Service, I043, 158-166).

The interviewees also referred to the need for practical investment in resources such as diagnostic equipment for primary care settings:

> *We have to look at primary care providing an enhanced service in certain areas and maybe they should have some sort of laboratory service available to them maybe they should have an x-ray facility available to them … I think it is essential to spend some more funding on primary care provided it's obvious that there is a return.(Service, I006, 276-289)*

5.6 Systems Pressure

The fifth category discussed under the theme 'The Future of the Health Services in Ireland' was systems pressure (SP). A total of two codes were included under the category SP. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 5.5 Codes, Definitions, Frequencies – Systems Pressure

Code	Definition	Frequency
FHSPAL	Future health services will have to tackle the problem of increases in activity levels in areas such as A&E, an increase in the numbers of patients in both acute and community services, and a demand for an increase in the number of beds in acute services.	23
FHSPPR	Future health services are likely to include an increase in private provision of services. This may be as a result of political pressure or as a result of consumer choice and availability of new private services.	35
	Total	58

A total of 58 segments were identified in the coding exercise, of which 23 referred to the activity levels within the system in areas such as A&E. Participants also raised under this code the issue of bed numbers and the desirability or otherwise of having increased numbers of beds in acute services. The remaining 35 segments referred to the issue of privatisation of services, which many participants saw as an inevitable trend in the future provision of health services.

Participants were very aware of the high level of media interest in the pressures that exist within the A&E Departments in major acute hospitals. In discussing these pressures, they chose to comment on issues such as the importance of developing primary care as an important dimension to the resolution of the problems that existed. The relationship between these pressures and primary care development was evident throughout the research.

> *The reasons why we have such difficulties in our A&E Departments is that we have such a poor primary care service and that our GP services are so inadequate, certainly out of hours…so I would say that we must strive for more integrated services. (Service, I067, 76-86)*

Participants' concerns about bed numbers generally amounted to a demand for more beds. Many participants suggested that the Irish health services had

fewer beds per head of population than comparable economies throughout the developed world *(e.g. Service, I001, 33-39)*. This is closely related to the issue of bed occupancy rates. Participants generally felt that occupancy rates within the Irish system were very high compared to Europe and that this produces considerable pressure on staff *(Education, I044, 100-108).*

Participants in the research also related the question of bed numbers to the pressures within the system caused by the increased numbers of patients / clients being treated. They stated that the population had increased significantly without a similar increase in capacity and that in addition *"the population profile has changed … there are higher dependencies and that does require an increase in beds" (Service, I008, 29-37)*.

The increase in numbers of patients / clients came in for particular mention in relation to maternity services reflecting the increase in the birth rate within the country in recent years (5.3):

> *The biggest issue facing us at the moment is the increase in birth rate … Probably from about 1998 year on year we have seen something between a 3% to 5% increase in this hospital. (Medical Consultant, I024, 12-21)*

The comments from the participants on bed numbers, bed occupancy rates and activity levels within the system echo concerns abut this issue within the HSE in general. In fact, a number of initiatives have been introduced in recent years to address the question and to analyse the issues. These have already been discussed in chapter 1 (1.3.2).

The question of bed numbers, the appropriate use of those beds that are there, the potential for alternative ways of treating patients who are admitted to acute hospitals and the integration of community and acute services is an integral part of all of the issues raised in this section of the research. The issues are similar to those discussed under the question of organisational structures (5.5). The comments made there about the HSE's Transformation Programme and its

overall policy to move towards community based services, integration of primary and acute services and removal from the acute services of those cases that should more appropriately be treated in the community are of relevance here.

The participants also identified a move towards increased provision of services by the private sector and a strong perception that there is significant political backing for this trend. A number of participants pointed out that public sector hospitals are increasingly using private service providers, and the *Treatment Purchase Fund*[20] was quoted as a good example of the trend towards private sector provision: *"The treatment purchase fund … is the only [element of the] health sector that has been increased. (Medical Consultant, I011, 53-57)*. Medical Consultants are now adapting their service provision strategies to take account of this trend:

> *I think our development here will be to increase our private capacity which we will use to provide care to public patients through the treatment purchase fund and other types of initiatives like that we will just channel the money through a different route but those beds will be private in the sense that they will be commercially run and privately funded and that's actually what we are looking at at the moment (Medical Consultant, I011, 93-104)*

This has fundamentally changed the way in which hospitals deal with waiting list issues. The participant went on to comment that the Treatment Purchase Fund had taken away all the pressure that existed around the management of

[20] Established in April 2002, the NTPF is one of the initiatives outlined in the *Health Strategy* (DoHC, 2001a) to reduce long term waiting lists. Now if a public patient is over 3 months on a public hospital in-patient waiting list for an operation they can contact the NTPF to discuss options for treatment in a private hospital. The NTPF sources treatment for qualifying patients in hospitals in Ireland, Northern Ireland and England. Patients who opt for treatment with the NTPF will receive their treatment free of charge.

waiting lists *"because we don't care anymore, it's not our problem the treatment purchase fund is responsible for our long waiters now. It's their problem. (Medical Consultant, I011, 149-156)*.

Service managers also expressed concern about the implications of the European Working Time Directive (HSE Employers Agency, 2007)[21] and the impact it will have on staffing numbers and roles:

> *We've got to look at the working time directive and how that impacts on doctors and the number of doctors that are out there and the care that nurses can give and substitution care. (Service, I006, 1148-1154)*

Concern was also expressed about the overall numbers of staff employed in the health services:

> *I think that one of the biggest challenges [for] the executive is in trimming down its organisational structure. For a population of four million, we are grossly top heavy, in terms of organisation. You could look after a population of four million with a small health board type setting, not with all the ones we have historically taken in. (Medical Consultant, I066, 118-127)*

The comment did not refer to the numbers of registered nurses in the health services. None of the participants expressed the view that there were too many nurses working in the services. It is worth pointing out in this context that recent research in the United Kingdom indicates that there is a growing body of evidence which suggests that higher numbers of registered nurses and a higher

[21] *The Working Time Directive (EWTD) for Non-Consultant Hospital Doctors (NCHDS)* was transposed into Irish law of the *European Communities (Organisation of Working Time) (Activities of Doctors in Training) Regulations 2004 (S.I. No. 494 of 2004)*. See discussion on this in chapter 2 (2.3.1.4).

proportion of registered nurses within the nursing workforce are associated with reductions in patient mortality, incidence of respiratory, wound and urinary tract infections, number of patient falls, incidence of pressure sores, medication errors. Higher numbers of registered nurses are also associated with improved patient functional independence and patient experience and perception of health care (West and Rafferty, 2004)

5.7 Accountability

The sixth category discussed under the theme 'The Future of the Health Services in Ireland' was accountability (AC). A total of eight codes were included under the category AC. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 5.6 Codes, Definitions, Frequencies – Accountability

Code	Definition	Frequency
FHACHS	The CEO of the HSE is now accountable for the services – not the Minister.	5
FHACAL	It will be necessary to ensure that accountability exists at all levels with the organisation, from the CEO and Finance Director through all clinical grades (including clinical accountability) and administrative grades. Clinicians cannot be allowed to opt out.	135
FHACCM	Clinicians will be expected to become more involved in the management of the services and as a result will need to become more accountable for the services they provide.	31
FHACIA	There will be an increase in the quantity and intensity of audit activity in future health services, examining issues of governance, value for money, accountability and quality.	25
FHACPM	Performance management will become increasingly important, managing and tackling underperformance.	26
FHACPP	There will be a significant increase in the degree of political scrutiny of expenditure in health to ensure public accountability for the investment	47

Code	Definition	Frequency
FHACVF	There will be a greater emphasis on the need to demonstrate value for money in the provision of services, including accounting for inputs, outputs and outcomes.	116
FHACCI	There will be a need for more critical incident analysis with reference to the tribunals of enquiry, complaints, litigation, pressure groups, in order to ensure that lessons are being learned and changes made.	15
	Total	400

The issue of accountability was the one that attracted most comments from participants in the research. The code FHACAL, which looks at individual accountability at all levels within the health services ended up with the highest number of individual segments of all codes (135). If it is combined with the code FHACVF, which concerns the question of demonstrating value for money within the services, and which generated a total of 116 coded segments, the total number of segments is greater than for any other category (251). The numbers serve only to illustrate the level of interest generated by the issue and the level of awareness among participants of its importance. There exists within the health services, based on the evidence of this research, a very high level of expectation that accountability, performance management and value for money will be a major issue in future health service provision. A notable feature of the feedback from the participants was the degree of consistency of opinion across all of the categories of participants in the research.

Participants frequently referred to the *Brennan Report* (Government of Ireland, 2003) and *Prospectus Report* (DoHC, 2003b) as being of great importance in drawing attention to the lack of accountability that had existed within the system to date. Similarly, frequent reference is made to the important role of the HIQA in defining and setting standards, in monitoring performance and in conducting independent reviews[22].

[22] See discussion on this in chapter 2 (2.3.1.2)

Service managers within the HSE are particularly conscious about the importance of accountability and the challenge involved in driving a culture of accountability throughout the whole system:

> *The accountability issue is huge. I mean we are as an organisation going to drive accountability every day and at the moment accountability within the system is I think not something that we score highly on and we have got to move to a situation where all of our processes and everybody who works within the system that there is accountability for it and that is going to be … a complete change in culture. (Service, I075, 126-144)*

These views are echoed by many participants and there is evidence of a high degree of expectation in relation to the role that HIQA will play in promoting and developing a greater sense of accountability within the system *(e.g. Director NMPDU, I009, 205-221)*

Participants expressed the view that the issue of accountability translates itself into taking responsibility for budgets and for delivering value for money within one's own area of responsibility, including nurses and medical consultants *(Service, I006, 204-216)*.

But the question of accountability goes beyond finance and budgets and requires an audit-based approach to assessing outcomes. It is not just financial accountability *"it's accountability on the best type of treatment we give the patients and there is not enough auditing of that done, auditing to see have we done it correctly" (Service, I006, 224-235).* This raises the question of *"personal and professional responsibility"* which will include more accountability for professional and managerial performance, with standards being driven and monitored by bodies such as HIQA and the professional regulatory bodies *(Service, I012, 165 … 254)*.

There is an expectation from service managers that HIQA will drive standards and protocols in a firm and authoritative way: "[The change] *will be subtle, probably driven mostly by HIQA if it does have what I would call the wherewithal, the credibility and the authority to actually drive clinical practice, the standards and protocols" (Service, I036, 105-110).*

The nurse participants in the research are clear about the fact that issues of accountability are a question of systems and processes, involving risk management and professional responsibility as part of a multidisciplinary team. Accountability is seen by service managers as something with a hard edge, that will affect contracts and the way in which people work. Ultimately, accountability is about demonstrating that what staff do is useful and is value for money and in order to do that research tools are needed that have the capacity to capture relevant data. This is a particular challenge for nursing and midwifery:

> *I think the other challenge to be hard nosed about it is demonstrating that what we do is useful. We don't gather useful data against which we can measure our performance and increasingly I think performance assessment is going to become part of our day to day work. (Regulation, I061, 403-427)*

Being held accountable is also related to the potential for litigation. The question of litigation raises the need for a review and assessment of the lessons to be learned from the critical incidents that occur from time to time in the public arena. Recent enquiries into problems within the health services have brought to light the importance of taking stock of what is to be learned from these incidents. Participants referred to a number of high profile cases that have been in the public eye (e.g. the so-called *Dunne Case* involving the National Maternity Hospital) and stressed the need for deeper reflection on the lessons to be learned from these cases and on the need to create more widespread awareness of these lessons *(Service, I006, 880 … 934)*

So to drive accountability, it is important that the system is capable of taking stock of and analysing the failures as well as best practice *(Regulation, I030, 247-260)*. This requires the development of good evaluation skills. A number of participants commented on the importance of evaluation, highlighting that it is something that requires more concerted development effort:

> *Probably the weakest part of our current system is the monitoring and evaluation and the feedback loop, getting that back in so that we can measure what we do with it. (Service, I057, 494-501)*

This has a very practical application to the development of programmes and initiatives in the areas of clinical services and of professional development. Participants expressed the view that development programmes and pilot initiatives need to be evaluated in more detail and the results of these evaluations made available as the basis for the development of new generation of programmes and initiatives *(Service, I006, 977 … 1013)*. It was stated that this was the best way to learn about what the real needs were and the most appropriate response to those needs.

This finds an echo in the desire expressed by policy makers that the *Clinicians in Management Initiative* (OHM, 1998 & 2003d) should continue in a revitalised and enhanced format[23]. Participants expressed the view that this programme had delivered real value where it was implemented, and that it had proven its ability to adapt to local conditions and local culture *(Policy, I025, 151…179).*

Evaluation of programmes and initiatives is closely related to the question of performance management and value for money. One participant, in commenting on the need for more value for money analysis added:

[23] For a detailed analysis of early experiences of involving clinicians in management through the clinical directorate model in an Irish setting see O'Shea, 1995.

> *I don't mean that in a negative way. I think … that part of the problem we have in the present system is that an awful lot of good is done and we have no way of counting it and therefore we have no way of proving that we are doing a lot of good" (Service, I048, 330-349)*.

Many participants referred to the fact that significant investments had been made in the system in recent years and that there was considerable pressure from within the political system to demonstrate that this money was being well spent. The participant commented:

> *There is a constant cry from the Government that no matter how much money they put into the health sector, they still have problems. They speak about huge increases in expenditure over the last ten years. (Service, I001, 86-92)*

The all-pervasive nature of health service provision and its impact on the population is perhaps what makes it such a live political issue that is likely to continue for the foreseeable future:

> *It is probably the only business in the country that has four million customers. Every single person in the country is a customer of the health service, every person who votes, every person who pays taxes, every person who consumes the health service has an interest in it and therefore that aggregates up to a major political issue. (Policy, I002, 205-214)*

This opinion is also reflected in the views of service managers, particularly from the point of view of seeing a return on the huge investment that is being made in the health services and *"a nervousness that there is a significant funding going into health and it doesn't appear to be addressing the needs of the people" (Service, I006, 13-21)*.

The question of the performance of the health service relative to the investment being made is also often seen by politicians as a direct result of poor management capacity within the service. Policy makers speak about the pressure they experience from ministers and politicians about what they perceive as *"indications of poor management" (Policy, I025, 330-336)*.

Academic commentators, who participated in this research, on the other hand point to the fact that the increase in expenditure in health in recent years should be set against many years of lack of investment:

> *OK there has been an exponential increase in the amount of money spent in health but that is after a long period of very little spend in health. So it is very easy for politicians to fan this type of thing and, you know, we are giving all this money and you are paying all this money through your taxes and yet what are we getting for it. (Education, I044, 88-97)*

In 2006 the National Council published *Measurement of Nursing and Midwifery Interventions: Guidance and Resource* Pack (National Council, 2006e). Part one contains a report on a study of nursing and midwifery interventions and the measurement of their outcomes taking place in Ireland. Part two contains the Guidance and Resource Pack, which aims to assist nurses, midwives and services to select and assess nursing and midwifery interventions as part of a movement towards promoting greater accountability and quality.

5.8 Quality

The seventh category identified under the theme 'The Future of the Health Services in Ireland' was Quality (QU). A total of two codes were included under the category QU. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 5.7 Codes, Definitions, Frequencies – Quality

Code	Definition	Frequency
FHQUPC	There will be an increased emphasis on putting the patient at the centre of service development and delivery and the monitoring of the patient's journey through a seamless service.	58
FHQUIN	Future health services will be delivered in a society with increased access to information, including internet based information. This will drive expectations of quality among consumers. Information technology will increase in importance as a way of managing information within the health service.	42
	Total	100

A total of 100 segments emerged from the coding exercise for this category, of which 58 focused on the question of increased quality of service delivery from the patient's / client's perspective, articulated most frequently in terms such as 'patient's journey', 'seamless service', 'patient-centred'. The remaining code focused principally on the question of information generation within the system and for / by the patient / client through better and more widely available IT systems. These codes reflect the reality that the health services are moving towards a future when information will become more readily available and easier to access and manipulate. It also establishes a correlation between the generation and use of information and quality service delivery.

The fact that consumers of health services will have higher expectations of quality and service in the future has already been referred to in section 5.2 of this chapter. Reference was made in particular to the fact that the consumer has become very smart and astute and aware of the difference between a poor quality service and a good quality service and knows when they are getting value for money and when they are not.

One of the participants commented on the fact that patients / clients frequently find out about a particular illness / condition first of all through soap operas on television, where illness and health is treated in great detail, including well researched and graphic depictions of signs, symptoms, diagnosis and

treatment (Policy, I014). Many of the participants referred to the wealth of information that is available on the internet and the fact that patients / clients are increasingly approaching the services with a lot of information about their condition already available to them. This enables them to engage with healthcare professionals and the healthcare system in a much more informed and authoritative manner. They have become empowered by information. Under these conditions therefore:

> *One of the things we are looking at, and again it is not particular to nursing, is that whole shift in terms of the relationship between the cared for and the carer and it is around this idea of empowerment. It is happening anyway. It is happening through the access to information and so on, the educational levels at which people generally are operating. The more information we feed them the more awareness / consciousness we are generating about health issues. (Policy, I014, 148-160)*

The participant went on to comment that the concept of an 'empowered' client / patient empowered through information and education is something that perhaps policy makers, professionals and service managers need to reflect more on. The participant expressed the view that it was important to *"make sure that people can get access to information that is authoritative and that can be relied upon"*, and that health care professionals needed to *"adjust around the more educated consumer"*. The participant concluded that *"This empowerment thing is at the centre of everything we have to do, we as policy makers, and you as professionals. Otherwise we will continue to replicate what we have done in the past and we can only get it wrong. (Policy, I014 171-184).*

The fundamental shift in the relationship between the carer and the cared-for has enormous implications for the culture of the profession. This point of view was articulated very strongly by some of the medical consultants who participated in the research:

> *A culture change is where doctors say we are not God, we know next to nothing, a little bit more than you do and you know that now because you can get on the internet and find out and say we know bugger all about much of the drugs we are prescribing. We just cannot. We are overwhelmed. There are hundreds of them. And now you are sharing that with us so let's talk as equals. (Medical Consultant, I021, 1683-1694)*

Availability of information, therefore, and the use of information and communications technology (ICT) has already changed fundamentally the way in which healthcare is delivered and promises to do so even more radically in the future. On the other hand, it is important that within the system there exists the capability to keep track of what is being done well and build on it. This highlights the need for system-wide mechanisms and information systems capable of supporting this kind of information. One participant lamented the fact that despite the increased emphasis on quality, *we can never say that we have in place structure … and mechanism of delivery and … for measurement both qualitatively and quantitatively of what we do (Service, I006, 626-651)*. Measuring what we do is seen as an essential ingredient in developing quality. This raises the question of research into clinical practice and the importance of building a practice based approach to research. This requires the health services to take a hard look at the way in which education systems and practice systems are focused:

> *To what extent our education systems, our research systems and our practice systems are capable of absorbing all of the knowledge, and we have not done it so far, we have been very poor in doing it so far. For example we don't have, I am not aware of any system in this country which is geared towards taking in best practice from different parts of the world, piloting it and then moving on and then mainstreaming it. (Trade Union, I068, 710-730.*

The development of systems such as these raises the question of the use of IT throughout the system as an aid to improving the quality and safety of the services we provide. Many of the participants reflected on the growing importance of IT skills and IT systems within the services and thought that *"the health service of the future is going to be an IT enabled service… and that everyone who works in it is going to be working as much in a virtual way as in a natural way. (Service, I008, 637…709)*.

The participant went on to describe the potential afforded by technology for online checking of results from laboratory tests, radiology tests, and the value and safety of relying more on electronic records rather than paper records. The participant referred to the much publicised example of a Cavan hospital where the death of a child whose file could not be found gave rise to an enquiry about the safety of paper records. Similarly, the use of bar-codes and computerised order entry form can all contribute towards the integration of the services and improved links between primary and acute services *(Service, I008, 637-709).* The participant then went on to comment on the need for shared information between professionals within a system where the information is owned by the client:

> *So I think that we are going to have to move into the modern world where health professionals share information and that the information belongs to the patient and we get away from these professional empires where you know doctors don't authorise nurses and nurses don't authorise others. All of it is creating huge risks for patients. (Service, I008, 637-709)*

The directors of nursing and midwifery who participated in the focus groups referred to expectations among the public about the potential impact of technology on health service provision. They spoke of major issues of public

expectation around the use of technology within the health services that need to be identified and addressed *(Directors N&M, FG01)*[24]*.*

One participant referred to *"the revolution that is taking place in the linkage of ICT to health technologies and it is nothing short of a revolution in e-health that is happening" (Policy, I014, 202-226)*. The participant concluded that it is likely that these developments will impact in a very significant way on the health services of the future in Ireland, including the way we conceive of and design the healthcare environment of the future.

Many of the participants in the research expressed views about the concept of a patient-centred approach to planning and organising the health services of the future. The move to more primary care based services is seen as central to this approach. Participants expressed the hope however that in this move *"that nurses don't lose* [sight of the fact that] *that the patient is at the centre and that they have the responsibility for everything that surrounds the patient. (Policy, I007, Extracts: 12… 216).*

The role of the nurse as an advocate for the patient is something that occurs frequently throughout the research and will be covered in later chapters (chapter 6 and 7). It is an important dimension of a move towards increased awareness of the need for patient centred approach to the development of high quality services:

> *I think again, not alone does the nurse have the missing bit to bring to that but they can maybe bring a little bit more patient consciousness or patient conscience or really patient orientation to it and that's not in anyway to insult the other professions that are involved. (Service, I048, 552-560)*

5.9 Culture

[24] See discussion on this issue in chapter 2 (2.3.1.3)

The eighth category discussed under the theme 'The Future of the Health Services in Ireland' was Culture (CE). A total of five codes were included under the category CE. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 5.8 Codes, Definitions, Frequencies – Culture

Code	Definition	Frequency
FHCECC	The future health services will present a significant cultural challenge.	24
FHCEID	The requirement for increased interdisciplinarity in service delivery requires the development of a new culture.	66
FHCETW	The need for increased team working requires the creation and development of a new culture.	62
FHCEPR	The relationship between the professions is an important part of the cultural change need for future health services.	19
FHCESI	The demands of future health service delivery will require the breaking down of the silos in which professions have traditionally operated.	29
	Total	200

The issue of culture is one that arises throughout this research and will recur in later chapters when we look at the themes of role change, education and skills. In the context of the theme for this chapter, however, a number of important interventions were made by participants that are worth highlighting. A total of 200 segments were identified during the coding exercise under this category heading, the majority of them (128) relating to the issue of interdisciplinary working (66) and team working (62). Both of these codes are closely related to the issue of relations between the professions within the health services (19) and the importance of breaking down the silos within which the professions have traditionally operated (29). These issues have significant implications for role change and professional development for the future so it is important to address them as an integral part of considering how the health services of the future will be developed and delivered.

The changes in culture required within the health services of the future are driven by the demands of the changes that have been examined throughout

this chapter: socio-economic changes (5.2), demographic changes (5.3), separation of policy and executive functions (5.4), changes in organisational structures within the services (5.5), pressures that exist within the services and that will increase in the future (5.6), new demands for accountability throughout the system (5.7) and a major increased focus on quality, driven by the opportunities and challenges posed by information availability and technology (5.8).

Each of the categories of participants were quite clear about the importance of a cultural change in the health services of the future. All of the participants also recognised that this would take time:

> *It will take time. A lot of these things are interlinked, changes in culture, if we want to deliver a better health system, we will have to have a change in culture. (Policy, I058, 70-74)*

The most significant change in culture that is required is in the area of team working and interdisciplinary working relationships between professionals. The need for this was related in one instance to the fact that medical errors quite frequently occur at the interface between the disciplines (professional, management, administrative, clerical) and that therefore the need for teams is driven by the need to reduce the potential for this kind of error to occur:

> *We are terribly hierarchical, very focused on our individual disciplines and all the literature shows…that major medical errors (and we have a lot of them) don't occur necessarily within the disciplines but at the interface between the disciplines whether it be doctors and nurses or the anaesthetists and surgeons or managers and professionals…because they don't talk to each other because professionals particularly and it's true for doctors aren't trained to the notion of team working and*

> *communication and that's where most of the problems arise. (Service, I002, 650-672)*

In considering the composition of multidisciplinary teams, the participants also made the point that teams are not necessarily always led by the medical professionals. There is a perception generally that the medics see themselves as natural team leaders and that is not necessarily the way it needs to be for the future:

> *But I think the challenges are to really get teams working well, to set up things like care pathways where everybody has big responsibilities and the teams work well. It also sets the challenges for the medics because the leader of the team does not necessarily have to be a medic and that is something that we have to really work on. (Education, I055, 464-473)*

Participants also spoke about the importance of inculcating an interdisciplinary instinct as part of the normal way of doing business. One participant referred to making the *"interdisciplinary instinct … part of the basic tool kit of any healing professional. (Policy, I014, 90-97)*

Working as part of an interdisciplinary team and improving the relationships between the professionals and other disciplines is an essential ingredient in improving the patient's journey, the quality of care. Participants who referred to the concept of *"the patient's journey"* also believed that where *"multidisciplinary[25] team working worked really well … it did improve the patient's journey. (Director NMPDU, I041, 319 … 378)*

Within the services, nurses are generally seen as being well disposed to inter-disciplinary team working. There is also ample evidence from within this

[25] The terms 'interdisciplinary' and 'multidisciplinary' are considered as synonymous throughout this work and are, therefore, considered to be interchangeable.

research that clinicians are positively disposed towards working in teams, with one medical Consultant participant describing multidisciplinary working as "*core".* The same participant went on to identify one of the problems of working in teams where *"doctors are more assertive, nurses are more assertive, physiotherapists, occupational therapists are more assertive; everybody is more assertive and more certain that their view is right" (Medical Consultant, I060, 232-245)*. The participant believed that this makes working in teams more challenging.

The creation of the HSE and the potential that it presents for a more integrated approach across the whole healthcare system is something that was seen as potentially contributing greatly towards the development of this culture of cross-discipline team working. Some respondents felt that interdisciplinary team working would significantly influence the way we organise the development and delivery of services. For example:

> *The antique nature of our out-patient systems, so that 80% of those attending out patients are still repeat visitors who largely have limited or no interventions carried out and are in the system simply because they are in the system and it seems to me that if we were to radically reduce the recurrent stable patient from those systems, and if we were to ensure that outpatients were to be used for specialist advice on difficult problems or new presentations and if were to have systems in place to control the patients with diabetes, hypertension, epilepsy, asthma, all of the other problems that cause our chronic disease problems at the moment, if those patients were better managed by interdisciplinary approach we would have better organisation all around and I think nursing has a profound role to play in all of that (Regulatory, I061, 131-155)*

Interdisciplinary working is also an essential ingredient of the hospital accreditation process that has become so valued in recent years. One

participant remarked that *"The concept of accreditation is an interdisciplinary approach to the evaluation"*. Accreditation therefore, looks at the interaction of all the disciplines in a hospital setting, including clinical and non clinical staff *(Service, I062, 188-208)*.

From all of the categories involved in this research a consistent clear message emerges:

> *We are moving towards a multidisciplinary method of service delivery I think more of an emphasis on collaborative working, more of an awareness of what other professions can do, less emphasis on demarcation and as I say more of a move towards common decision making as well. (Service I064, 394-402)*

5.10 Conclusion

It is possible to identify a number of key conclusions from this research about the participants' view of what the health services of the future will be like in Ireland. These can be summarised in the following points:

1. The health services of the future will be delivered to a population that will be wealthier, with higher expectations about what they can expect from public services. This affluence will generate a culture where patients and clients expect services to be delivered without the need to wait and to a high standard of quality and personal service.

2. Consumers of health services will place a large emphasis on value for money from the services. They will be more informed about what constitutes 'good service' and will demand a higher quality of service. This will change radically the relationship between the consumer and the service provider and between the consumer and clinical professionals. The leaders of the services of the future will need to give consideration to the changes in

expectations of consumers in the development of service infrastructure. 'More of the same' will not be acceptable.

3. Ireland's population will continue to grow at a fast rate and the birth rate will continue to increase. This means that there will be a higher demand for health services that are adapted to the profile of the population.

4. Health service consumers are concerned about how older people will be treated within the health services of the future. This is further exacerbated by changes in the structure of the family and the disappearance of traditional support structures. This has significant implications for the health services and the nature of support that can be provided to carers and to people in their own homes.

5. The population of the future will be working more, with a higher level of female participation in the workforce. This will lead to further fragmentation in the nature of family relationships and the support structures that are there.

6. Increased wealth will bring with it an increase in lifestyle diseases such as obesity, diabetes and alcohol and drug-related illnesses.

7. The population of Ireland will continue to become more ethnically and culturally diverse. This has significant implications for the delivery of services and in particular the need for sensitivity to cultural differences and communications issues. It also raises significant questions for the recruitment practices within the services and the need for increased training for professionals and administrators in dealing with a more diverse population and consumer base.

8. The health services of the future will be delivered by a single unitary accountable entity. It will lead to a greater degree of accountability within the system. The creation of the HSE should lead to greater equality of access to services and to the development of higher standards in the delivery of services. The HSE is likely to face pressure for increased integration of services and administrative structures and, in particular, to

revise the division between the two pillars PCCC and NHO (Appendix 1 and 2). The structures as they are currently configured are more suitable for bureaucratic control and distribution of funding resources than for service delivery management. They are also not conducive to the clinical management of services[26].

9. In order to make progress in the integration of services, there is a need to review the involvement of clinical leaders at all levels of the health service delivery structures. This may require the creation of posts at national and regional level for clinical coordination, involving hospitals and primary care teams. A clustering system may be appropriate with a view to bringing together primary care and hospital structures within regional and local geographic areas.

10. This entails significant changes for the role of the DoHC and will drive cultural changes in areas such as political accountability.

11. The creation of the HSE should lead to greater equality of access to services and to the development of higher standards in the delivery of services.

12. The health services of the future will see acute hospitals focus entirely on major acute interventions. Service delivery will shift to the primary care setting in the community, with an increase in initiatives such as the Hospital in the Home (HITH) and Community Intervention Teams (CIT).

13. The shift of emphasis towards primary care settings has significant implications for health care professionals. They will follow the patient into the community and most of them will be working in community bases rather than acute hospital settings. This has significant implications for the education and training of professionals.

[26] See discussion of this in chapter 1 (1.3.2 and 1.5).

14. Patients, consumers of health care services can expect to receive more services within their own homes and within their own communities, delivered by professionals who are based in the community. Many services will be nurse-led. There will be a system of primary care based interdisciplinary and multidisciplinary teams, including and sometimes led by the GP.

15. Nurses and midwives within the community will be expected to link together better and to link with other professionals as part of multidisciplinary primary care teams.

16. There will be an increase in the number and nature of 'networked' hospitals, involving close links between various hospitals and academic institutions.

17. There will be an increase in the availability of diagnostic and assessment services that do not require admission to hospitals. Length of stay in hospital will be shorter and there will be more protocol based early discharge arrangements in place. Professionals will follow up with the patient in the community.

18. There will be an increase in the provision of private health services. Consumers will be offered and will avail of greater choice.

19. The health services of the future will be delivered with a very high emphasis on personal and professional accountability within the system. This has significant implications for managers and clinical professionals within the system, who will expect to be accountable for their area of service delivery and be called to account for the value for money of their services.

20. Standards in both private and public health care provision will be driven by HIQA and the respective regulatory bodies of the different professions. This will mean a significant increase in the quantity and intensity of audit within the system, with consequences for the way professionals account for their work.

21. Political pressure will increase for evidence of value for money in the provision of public finances for health services.

22. The health services of the future will be delivered in an environment where the client, consumer, patient is more empowered. He/she will be in possession of more information, of a higher quality and will expect to be treated as an equal in discussing the services they require. This has significant implications for the relationships between patient or consumer and health care professionals and administrators. It also has significant implications for the quality of services that will be expected.

23. The services of the future will be driven by a greater and more wide spread use of technology, in particular information and communications technology. This will lead to an increase in the level of technology-driven services, the availability of e-health options and the networking of professionals and systems across institutional boundaries. It will underpin the increased emphasis on community-based services and remote consultation.

24. Nursing and midwifery will have an important role in continuing to act as an advocate for the patient in what will become a patient centred health service with emphasis on integrated care pathways and the patient's journey.

25. The development of the health services of the future will require a transformation of the culture of the professions. In particular it will demand a multidisciplinary method of service delivery, a greater emphasis on collaborative working, a greater awareness of what other professions can do, less emphasis on demarcation and a move towards common decision-making.

Chapter 6 – Results and Discussion 2 – The Changing Role of Nursing and Midwifery in Ireland

6.1 Introduction

The interview schedule for the semi-structured interviews (Appendix 18) (4.7.1) devised as part of the methodology for the research, included a number of questions and probes to be used in the interviews. Five of the twelve questions referred to the changing role of nursing and midwifery in Ireland. The questions and probes used are reproduced here for convenience:

Questions 3 – Do you think the role of nurses and midwives will change significantly over the next 10 years? (If no – explain why not; if yes – In what way will it change?)

Question 4 – In what way do you think the new role will differ from the current role?

Probes for Questions 3 and 4:
Nurse / midwife-led services?
Proactive in change initiative?
Proactive adaptation to service needs?
Interdisciplinary teams?
Relations between acute and primary care settings?
Prescribing?
Education?
Specialisation?
Involvement in management?
Accountability?

Question 5 – Do you think General Managers and Nurse / Midwife Managers understand the way in which the role of nurses and midwives will change?

Probes for Question 5:
Preparedness for change?

If no – why do you think that is and what should be done to change it?

If yes – how do you think this was achieved and how is it demonstrated?

Depth of understanding of the problems and issues within the existing structures?

Question 6 – In what way will the relationships between the various professions and grades involved in the delivery of the health services change in the future?

Probes for Question 6:

Common education?

Team working?

The management and cultural implications?

Question 10 – What are your opinions of the current level of preparedness of nurses and midwives for the challenges ahead?

Probes for Question 10:

Recent changes

Impact of Commission on Nursing

Quality or lack of quality of CPD?

These five questions combined to provide a picture of the opinion of the interviewee on the changing role for nursing and midwifery in Ireland – the second of the themes to be identified (RC).

Within the general theme of the changing role for nurses and midwives in Ireland, the following categories were identified based on the comments of the interviewees:

Clinical career pathways (CW)
Leadership (LE)
Nurse / midwife-led services (NL)
Interdisciplinary teams (IT)
Relationships between primary and acute care services (PA)
Adaptation to role Change (AD)

These categories provide convenient headings under which we can analyse the individual codes that emerged under each of the categories. This chapter provides an analysis of the comments made by the interviewees under the theme and categories listed above.

6.2 Clinical Career Pathways

The first category identified under the theme 'The Changing Role for Nurses and Midwives in Ireland', was clinical career pathways (CW). A total of six codes were included under the category CW. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 6.1 Codes, Definitions, Frequencies – Clinical Career Pathways

Code	Definition	Frequency
RCCWMS	There is a need for more specialist nurses in future health services.	75
RCCWDS	Increased specialisation in nursing has some inherent disadvantages.	18
RCCWAP	ANPs and AMPs are an important dimension of specialisation and role change for nurses and midwives.	46
RCCWCO	Specialist nurses will need to develop new relationships with Medical Consultants.	2
RCCWNC	The existence of more specialist nurses and midwives will require an examination of the changes in the relationships with NCHDs.	13
RCCWSN	It is important to provide staff nurses and staff midwives with access to a meaningful clinical career pathway.	9
	Total	163

A total of 163 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided[27].

There is universal agreement among all participants in this research exercise that increased specialisation is both necessary and good for nursing. It is also seen as following best practice internationally and service managers comment that new Medical Consultants arriving will frequently expect to be allocated a CNS or ANP. In some cases they even express a preference for specialist nurses over junior doctors:

> *I have noticed in recent years if a new Medical Consultant comes the first thing they look for is a CNS … I have noticed that when Medical Consultants have their shopping list and that is a clear indication to me that CNS play an absolutely vital role in service provision. This will become even more important going forward with the European Working Time Directive. (Service, I001, 539-568)*

In areas of the country where ANPs had not yet been introduced, the demand was frequently created by new incoming Medical Consultants, particularly those who had worked abroad.

Participants in the research raise the question about the impact of the clinical career pathway for nurses and midwives on the implementation of the EWTD provisions[28]. They raise questions about the opportunities presented by the development of the role of nurses and midwives.

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[27] The quotations provided are taken from the texts of the interviews and focus groups. They contain reference to the category of interviewee involved in the semi-structured interviews (Policy, Service, Medical Consultant, Education, Director NMPDU, Trade Union, Regulation), or participant in the focus groups (Directors of Nursing and Midwifery), the number of the interview / focus group and the line numbers within the transcribed / coded text.

[28] See discussion on this in chapter 1 (1.3.4)

Medical consultants are clear about the advantages of more specialists and the role they can fulfil in relation to the implementation of the working time directive. In addition to the benefits of having nurse specialists *"with nurse specialists now taking over roles to a degree were fulfilled by doctors before, particularly junior doctors … but here now … nurses would run clinics and there is actually huge advantages to it because you have continuity you can work within an agreed pathway of protocols (Medical Consultant, I011, 295-316)*. The same is true in areas such as midwifery, where Medical consultants spoke about the benefits of having clinical midwifery specialists *(Medical Consultant, I033, 154-158)*.

The role of the ANP is seen by Medical consultants as a welcome expansion of the role of the nurse, which does not replace the role of the medical practitioner but enables it more and has become increasingly indispensable in certain areas of service provision. As one of the participants put it: *"we couldn't survive without ANPs … we have nurse practitioners here or CNS and they actually are all the time involved with the patients explaining the use of the drug, the use of the syringe, how to give it, if there are any problems to contact them, and all of that. So it enables a service that would not other wise be as effective. (Medical Consultant, I065, 207…281)*.

So it is clear from that text that nurse / midwife specialists (CNS/CMS) and advanced practice nurses and midwives (ANP/AMP) enable services to be provided that would otherwise not be provided and add significantly to the overall effectiveness of the clinical team, to the decision making process and to the delivery of services.

Participants in the research with a nursing background were generally very favourably disposed towards the idea of increased specialisation within the profession and were very much in favour of the role of CNSs and ANPs. Nurses also feel that as the specialist roles develop into other areas and, in particular, once audits of their work are done, the real benefits of this approach will become apparent.

The Directors of the NMPDUs also raise the potential for nurse specialists to provide support to nurses in more generalist roles. A number of participants felt that there is a need for balance, and that the role of the generalist nurse in the clinical area is one that is very important.

> *Specialisation is important, I accept that and that goes without saying but there is a need for someone who as a generalist knows who to call or when to call. (Service, I063, 202-206)*

The directors of nursing and midwifery who participated in the focus groups also emphasised the great contribution nurse specialists were making to the overall quality of clinical services and would welcome their wider involvement outside their specialist clinics and in the general areas to lead nursing care:

> *I think we will see increased specialization though. We have already seen the advantages of having specialist nurses. They bring a huge change in the quality of care that is delivered to patients and the specialist knowledge that is brought to the wards has changed so much as a result of having specialist nurses on the ground and I would really like to see it become more involved in clinical practice out there with the generalist nurse as opposed to being isolated in their own clinic and their own specialty area and that we try and bring them out there to enhance care more because they are really good. (Directors of N&M, FG01)*

The directors of nursing and midwifery related this idea to the idea of Patricia Benner – novice to expert (Benner, 1984), where the specialist nurses plays the role of the expert helping the novice along the pathway and using her judgment to address the many critical issues nurses and midwives face on a daily basis within the clinical area. Benner also introduced the idea of *Clinical Wisdom* and *Clinical Judgement* as part of the characteristics of an expert nurse

in her book *Clinical Wisdom and Interventions in Critical Care: A Thinking in Action Approach* (Benner et al, 1999). The participants commented:

> *I suppose the novice to expert model is a very good one, that they have the skills depending on what level they are at. I think one of the mistakes we make is that we are not looking at the years of qualification that nurses have out there but that we do have novices out there but there is a reluctance on the more experienced nurses to actually develop those novices and bring them along and I think we have to focus on that much more in the future. (Directors of N&M, FG01)*

Participants with a nursing background however predominantly saw the move towards specialisation as evidence of nurses taking a greater leadership role in the clinical area:

> *In looking at CNS and ANP development, I am seeing very much more in nurses taking on responsibility and contributing within the service areas and really looking at taking on leadership roles. (Education, I055, 204-211)*

The move towards increased specialisation within nursing raises the important question of measurement of impact and effectiveness[29]:

> *Once people are specialists they need to be constantly monitored as well and that is going to be important because people are going to be judged by outcomes and again how is all this achieving a better service for the public? How is it contributing to greater accessibility for patients? And that really will be the final arbiter in deciding whether or not nurses can meet the challenges and whether or not any*

[29] See discussion of evaluation of roles by National Council in chapter 2 (2.3.2)

changes that have been proposed have been effective. (Service, I064, 354-367)

6.3 Adaptation to Role Change

The second category identified under the theme 'The Changing Role for Nurses and Midwives in Ireland', was adaptation to role change in the health services (AD). A total of eight codes were included under the category AD. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 6.2 Codes, Definitions, Frequencies – Adaptation to Role Change

Code	Definition	Frequency
RCADPA	Nurses and midwives need to be proactive in adapting to role changes.	24
RCADCW	The clinical career pathway is an important element of adapting to change in role changes for nurses and midwives.	21
RCADPS	There is a need for nurses and midwives to become involved in prescribing as part of the future role change for nurses and midwives.	51
RCADPX	Are nurses and midwives prepared for the changes ahead?	74
RCADUX	Do nurse managers have a good understanding of the way the role of nurses and midwives will change?	48
RCADGM	Do general managers have a good understanding of the way in which the role of nurses and midwives will change?	47
RCADRX	There is a problem of resistance to change within nursing and midwifery, particularly in relation to changes of role.	21
RCADTU	There is a problem of resistance to change from within the Trade Unions that represent nursing and midwifery.	37
	Total	323

A total of 323 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided.

Participants reaction to the probes contained in the questions (6.1) focused on a number of issues which were reflected in the segments. A good number of participants expressed the view that nursing and midwifery would need to be proactive in adapting to change (24); a similar number (21) mentioned the clinical career pathway as a good indication of the way in which nursing and midwifery was adapting to change and commented on the additional potential that this offers. A significant number (51) responded to the probe on nurse and midwife prescribing by commenting on the importance of this as a practical demonstration of nurses and midwives adapting to change. The interviews and focus groups also provided the opportunity of sounding out participants on their views of the degree to which nurses and midwives were actually prepared for change (74) and whether nurses and midwife managers understood the change that was necessary (48) and whether general managers understood the kind of changes that lay ahead for nursing and midwifery (47). Finally, participants also chose to comment, without being probed, on what was termed 'resistance to change' within nursing and midwifery (21) and from within the trade unions (37). It is clear from the volume of segments that emerged from the coding exercise that participants found the topic of change to be an important and wide ranging subject.

As we have already discussed in relation to the clinical carer pathways (6.2), this was seen as a very positive outcome for nursing from the work of the Commission on Nursing. A number of participants felt however that it would be important to provide nurses and midwives with some career guidance, counselling or support services in order to encourage them to reflect on the career pathway that would suit them best. This would, from an economic perspective, ensure better value for money from the investment in their training and development, trying to ensure that they did not spend a long time in a career path that did not suit them. One such suggestion for example stated that:

> *After about 2 years in practice, [nurses and midwives] should be encouraged to devise a career pathway for themselves. (Service, I006, 726-729)*

Such an approach will also ensure that nurses who are particularly suited to management or clinical career pathways, or who might be better involved in education, professional development or research, will have an opportunity to find out sooner rather than later in their careers and be facilitated to take that path. This discussion raised the possibility of career pathways other than clinical career pathways to be identified within the profession. Mention was made of the opportunities that existed within management, education, research and professional development. In order to ensure that nursing and midwifery adapts to change in a proactive manner, career advice and support on these issues was seen by participants as important, especially early in their career.

Participants also referred to the need for nurses and midwives to take advantage of opportunities presented under the emerging strategies for the development of primary care services and extension of the roles of nurses and midwives to proactively adapt and lead the change in these areas. This is a topic that has already emerged in other sections within this chapter and elsewhere (5.5) when discussing changes in nursing roles.

With regard to the comments made by participants on the question of nurses and midwives prescribing, it is important to remember that the inclusion of this probe in question 4 of the research (6.1), was related to the fact that a national study was being conducted at the time on the involvement of nurses and midwives in the prescribing of medicines[30]. As a result of the national initiative on prescribing for nurses and midwives, there already existed a high degree of awareness within the healthcare services of this issue. It is not surprising therefore that 51 segments were identified that referred directly to the topic.

There was universal agreement between participants in this research that the involvement of nurses and midwives in prescribing was both desirable and inevitable. At a policy level, it was pointed out that this is already happening in

[30] See discussion on nurses and midwives prescribing in chapter 2 (2.3.4)

other areas of the medical services, and that therefore it made no sense not to do something similar in nursing and midwifery:

> *Progress has already been made … on the medical technicians where a Statutory Instrument is being prepared to allow certain drugs to be given in emergency situations. (Policy, I005, 329…334)*

Many of the participants referred to the need for proper training and education in order for nurse and midwife prescribing to provide the service with the required degree of confidence that a particular person is a competent practitioner to prescribe. Participants also considered whether it should be confined to a limited number of medications (the list method) and in general the feeling was that it should not be.

> *I mean people talk about minor things like panadols and whatever but I see it as a lot more; in a lot of cases there is no reason why psychiatric nurses cannot prescribe appropriate medication, in a lot of cases they would have a lot more experience with psychiatric patients out of hours than some of the junior doctors; the same in paediatrics, the same in ICU. (Service, I006, 355-365)*

Similarly Medical consultants in areas such as midwifery and care of the elderly support the idea of nurses and midwives having a wide role in prescribing provided they have had the appropriate education, training and certification.

Participants also considered the pros and cons of limiting prescribing to CNS/CMS and ANP/AMP. This is something that has been an important part of the debate that has been conducted at national level on the question of prescribing, and there was not total uniformity on this. Thus for example one of the participants felt that *"you are looking at your ANP level being involved in the prescribing process. (Director NMPDU, I009, 383-386)*. Similarly, another participant saw it as *"a perfectly logical extension of a specialist role. (Medical*

Consultant, I011, 472-473). On the other hand, one of the trade union representatives in the research expressed the hope that the development of these skills and competencies would not be confined to an elitist group of nurses and that it would be done in a way that empowered the staff nurse. This view found an echo in a number of other participants as well.

The issue of prescription of medication raises the further question of the involvement of nurses and midwives in ordering radiology and laboratory services. A number of interventions from policy, service and Medical Consultant categories of participants in the research saw this as a logical extension.

Finally, one participant from the services summed up the overall view on this issue in a succinct manner by saying *"I don't think nursing will move very far unless they move into areas of prescribing and they are central to the new ways of working. (Service, I052, 280-283)*.

The involvement of nurses and midwives in prescribing therefore is seen as a logical extension of all of the other changes in the delivery of services that are emerging within this research and of the role that nurses and midwives are expected to play within it.

On the question of 'preparedness for change', a total of 74 segments were singled out from the interviews during the coding exercise. The 74 segments identified represent almost 100% coverage of the participants in the interviews (76). The probes used in the question (6.1) invited participants to elaborate on the reasons for their position, whether yes or no, and to comment on how they thought this had come about and on the depth of understanding of the problems and issues that existed within nursing and midwifery on the issues.

In the member checking exercise that was conducted as part of the exercise in checking the validity and reliability of the analysis of data (4.4), the respondents were split 60/40 against the statement that nurses and midwives were prepared for change. Of course in the member checking exercise, respondents were asked to state whether the agreed or disagreed with a particular statement. In

the interviews and focus groups participants had an opportunity to expand more, and as a result a slightly less clear cut picture emerged, as one would expect. As one participant from the service category put it "*the vast majority are sheep following the shepherd and that is your normal frequency distribution; most of them in the centre; there are a few out there. (Service, I053, 395-399)*.

While the participants used expressions like 'patchy', and 'somewhat', and 'don't know for sure', overall the impression from each of the category of interviews is quite positive. Thus for example:

> *Nursing has probably been the area where people have become most aware of the need for change and it is still a long way behind what we require but I think they are a long way ahead of other therapies than medicine in terms of understanding that their role is going to change. I think that the whole CNS and advanced practitioner model is now very well understood. (Service, I075, 759-771)*

That text summarises well what the service participants in general are saying about the preparedness of nurses and midwives is like. Many mentions are made of the impact of the work of the Commission on Nursing and the work of the National Council in implementing the clinical career pathways, of the value and impact of the introduction of the degree programme in education, of the likely impact that changes in education will have on the levels of awareness of nurses and midwives progressively as the new qualified staff come on stream. Similarly, the point is made that those members of the profession who have participated in continuing professional development activities, which are seen generally as beginning to have an impact, are much more aware and have a greater understanding of the role changes that are happening. The value of post graduate training is also mentioned as a significant contributor to this increased level of awareness, particularly the fact that a larger number of nurse managers increasingly have Masters Degrees, MBAs and other similar qualifications.

Medical consultants who participated in the research share the same degree of realism about the spread of the level of preparedness. However they spoke also about a cohort of nurses and midwives who *"are not heavily into the academic side of nursing and they are very frightened – no frightened is the wrong word, but they are disappointed. They feel marginalised". (Medical Consultant, I060, 621-631).*

That same note of realism is also present in the comments made by the nursing participants in the research. They speak about some concerns they have about the extent of the awareness within the profession, about 'cohorts' that are prepared for change, but uncertain about just how big that cohort is. It is also related to the extent to which professional nurses and midwives engage in continuing professional development activities or post graduate education.

> *It is worrying sometimes because we are in the middle of the biggest change ever in the State. It is exciting… (Director NMPDU, I049, 281-283)*

Those involved in education are perhaps closer to the cohort that is more likely to be prepared. Their interventions however also contain that note of caution and realism:

> *We are partially there but at the same time I think you know that nurses are a funny group because I think sometimes we are so rigid and so reactionary and yet look at what we have coped with over the last 20 or 30 years. (Education, I044, 2062-2069)*

Overall therefore, what emerges is a realistic picture of a large group of professionals within the system in transition through a period of significant and far-reaching change that will take time. The levels of awareness that exist within the profession are perhaps what one would expect and contingent on factors such as levels of involvement in education, professional development and the specific roles in which they are engaged.

The segments identified under the codes dealing with nurses and midwives' and general managers' understanding of change confirmed the picture that has emerged from the code on preparedness for change. Many of the participants spoke about initiatives that were in place to inform the profession about the changes that were emerging:

> *We would meet up with the Directors here 3 or 4 times a year and they are fully briefed and I know our own practice development people are working very closely with the assistant directors, divisional nurse managers, and CNM2s. (Director NMPDU, I009, 630-637)*

The Directors of the NMPDUs also speak about the work they do with the general managers, including for example encouraging them to participate in briefing sessions, attend national conferences organised by the National Council. This inclusion and proactive briefing is seen as an important dimension of building understanding and buy-in. The level of understanding that exists within general management is accepted by the directors of the NMPDUs as a challenge to them:

> *For general managers, whether or not they understand will depend largely upon us as nurse leaders in how we influence them. (Director NMPDU, I049, 266-269)*

Similarly educators within nursing, speak of the opportunity for leadership within the profession (administrative, managerial, professional, education) to develop understanding within nursing and within general management (Education, I052, 357-363).

Directors of NMPDUs, however, also make the point that there is still a lack of understanding about how the relationship between nurse management and general management needs to change. There is a lack of clarity about the sharing of responsibility and the complementarity of their roles. This is a fault

of both sides and is evidence of confusion within nursing itself about its overall role in management (Director NMPDU, I026, 281…) One of the directors spoke about an experience of interviewing a very competent and highly skilled nurse, with experience in a system where she had budgetary control and was used to making decisions as a key player within a directorate system. She turned to the general manager who was interviewing with her and asked *'are you ready for her? If you don't embrace what she has she will be gone' (Director NMPDU, I041, 1065…).*

Medical consultants who have already developed good working relations with their general management and nursing and midwifery colleagues speak enthusiastically about the degree of understanding that exists of the changes that need to take place *(Medical Consultant, I024, 243-246)*. Other Medical consultants however speak about their frustration at the lack of understanding of change that is needed at both general management and nursing management levels *(Medical Consultant, I066. 275…).*

Finally, from a service management point of view it was pointed out that it is only when one sees something working that real understanding occurs and for that reason the emphasis has to be on getting things moving, not waiting for everybody to understand *(Service, I075, 488…)*.

On the question of resistance to change, a total of 58 segments were singled out from the interviews during the coding exercise. The comments emerged from a consideration of the probes dealing with preparedness for change and proactive adaptation to change. There were however no direct probes on the topic of resistance to change and should therefore be considered as having largely emerged spontaneously from unsolicited comments made by the participants. The two codes involved picked up on comments made by participants on the topic of resistance to change from within the profession of nursing and midwifery itself (21) and as a result of the involvement of Trade Unions (37).

A number of participants in the research reflected on the role of the trade unions at the time of the Commission on Nursing. The *Commission on Nursing Report* (Government of Ireland, 1998) was launched in 1998. In 1999, the Government had not implemented the Commission's recommendations and nurses voted again for strike action. In October 1999 nurses and midwives engaged in industrial action. The strike lasted from 19 October to 27 October 1999. At the time, many nurses expressed dissatisfaction with the way the strike had been handled, including the initiation, management and outcome of the strike; many felt that a different approach could have achieved more. A number of the participants in this research expressed the view that the strike emphasised the power of the unions and resulted in a marginalising of the role of the Director of Nursing.

A number of participants spoke about the pressure from trade unions on senior nurse and midwife managers. As a result of this pressure, many Directors of Nursing and Assistant Directors of Nursing resisted the introduction of change because of the fear of falling foul of the unions. Participants in this research also stated that the trade unions had too much influence on the wider nursing profession and were not a beneficial influence; they held the profession back and resisted change. One participant referred to *being dictated to by a lot of males, who are looking at their own* [trade union] *careers rather than the totality of the profession (Service, I015, 451-454)*.

Participants also spoke of the cohort of nursing and midwifery who were trying to implement and lead change. The overwhelming picture that emerges however is of a profession that has become too preoccupied with industrial relations agendas, is dominated by trade unions, is fearful of change and too ready to row back progress and change that has already been made. These views were expressed by all categories of interviewees, and should be balanced by the more positive views expressed by participants when talking about nursing and midwifery's general ability to adapt to change as discussed at the beginning of this section.

The reality of continued industrial disputes and complaints created bitterness in some quarters:

> *The hope I had of changes arising from the commission are not obvious and I don't see signs either that that's going to happen and that is a perception from a distance but it would also be a perception that I would hear talked about. (Service, I008, 300-315)*

Another Policy participant makes reference to the industrial dispute that followed on from the publication of the *Report of the Commission on Nursing* in 1998 but however recognises that huge change has happened since then:

> *So 1998 was the Commission on Nursing and 98/99 was the industrial relations problem; nothing moved. Effectively things started rolling towards the end of 99/2000 … the profession itself is still coming to terms with that…maybe at some stage we need to step back … and have a look critically at where we are going; have we done it right, are there changes needed? (Policy, I031, 562-587)*

In the focus groups, the directors of nursing and midwifery lamented the slow pace of implementation and the negative effect the industrial relations issues had on this. The overwhelming impression of the Commission on Nursing however is that it lifted nursing and midwifery in Ireland onto a new level, however nursing and midwifery is also aware that not enough has changed in the style of management within nursing:

> *I'd like to say that the impact of the Commission on Nursing has been huge but the 'command and control' style of management still exists in some areas particularly mental health nursing and community nursing.(Director NMPDU, I054, 230-235)*

The reference in this text to the 'command and control' style of nursing raises memories of the very harsh criticisms that were made of nurse management in the *Interim Report of the Commission on Nursing* (Government of Ireland, 1997c; 3.1). At the time nurse management was characterised as being predominantly old style, with a lot of bullying in evidence within the services: "*Many nurses in discussions at the consultative for a and in written submissions complained of bullying in the workplace … It appeared that bullying may be taking place at a variety of levels within nursing. Complaints were made of students being bullied by nurses, nurses being bullied by other nurses and professionals, nurses being bullied by nurse management and nurse management being bullied by general management."* The vision of management for nursing provided in the *Report of the Commission on Nursing* was intended to move beyond that. When commenting on issues in senior nurse management, the report said: *"It was suggested that senior nursing and midwifery management operated on the basis of command and control rather than consultation and the delegation of responsibility."* (Government of Ireland, 1998)

Some service managers in particular express considerable frustration with the focus on industrial relations issues within the profession:

> *Nursing is much too industrial relations focused and the profession is hampered by that obsession with industrial relations. (Service, I008, 224-228)*

That participant also spoke about the lack of confidence within the system in nursing's ability to tackle these issues. It was felt that whenever an industrial relations issue arose the first thing that suffered were the professional development advances that had already been achieved. They were used as tools in the industrial relations negotiation process. Nurses stopped doing what their professional development advances had introduced. This frequently also led to legalistic interpretation of guidelines, which made it in some cases impossible to deal with practical issues on the ground for the benefit of patients.

This led to service managers expressing frustration at the slow pace of professional development:

> *The development and evolution of nursing as a profession…will not be addressed by the industrial relations arm of the profession… they have a vested interest in blocking the candid development that would allow nursing as a profession to be of the highly skilled kind. (Service, I008, 356…366)*

The issue comes back to leadership in nursing (6.5; 6.6) and the lack of it[31]. Participants commented on the leadership that is given on the industrial relations side of nursing and lamented the fact that the same energy and leadership is frequently not evident in the development of the scope and practice of the profession. The trade unions have dominated the professional development debate in the past and used it for industrial relations purposes rather than for the benefit of the profession as a profession. This is because the leadership was not available within the profession, the leadership competencies were not there. There was a recognition that this had changed with the arrival of the National Council:

> *In the absence of a body like the* [National] *Council here in the past the unions or interest like trade unions saw an opportunity. (Service, I012, 223-226)*

Nursing participants also recognised this problem. There is a strong union influence at local level that is impairing change and progress: *"We do have a strong culture of militancy and unions within the service… That needs to be addressed. (Director NMPDU, I009, 225-229)*.

[31] Much of the material raised here echoes the findings of the empowerment study (DoHC, 2003g) discussed in chapter 2 (2.4.2). It is worth re-visiting that material as a context to this discussion.

A number of service managers spoke about the difficulty of getting nurses to cooperate during a strike to cover genuine emergency cases:

> *It came home to me in the last negotiation I had around the A&E strike, when I almost had to beg to get emergency cover for the patients. (Service, I043, 383-387)*

The example of introducing health care assistants was mentioned by one service manager who commented on nurses *'holding onto their territory'* and *'protecting old boundaries'* (Service, I067, 283…287).

Frustration was also expressed by service managers at the inability of nurse management to identify themselves with management in industrial relations disputes. The nursing unions constantly criticise *'the management'* for all of the problems that they see, but do not take account of the fact that nurses and midwives are a large cohort of *'the management'*. Nursing management in turn is cowered by the power of the unions and fearful of stepping up to the line to tackle industrial relations issues from a management perspective.

> *It is as though it is not their responsibility; they don't see their managerial role as having any particular relevance or it is as though they are playing down their managerial role. (Service, I067, 414-420)*

Some participants linked the pressure that is on nurse managers in this area with the difficulty that is experienced in attracting applicants for some senior nursing management posts: "*People are not going into management roles or taking on other roles because of the sheer pressure that comes on them and demand coming on them". (Service, I022, 607-611)*

Nurses are deterred from applying for nursing management posts and nurse managers are reluctant to take on the management role because of the culture that exists beneath them and that rises up against them. Service managers speak about the need for this culture to change but express frustration at the

ability to change, with some of them saying that they do not detect an ability to change it within the profession. Those who do speak about how to change it refer to the need to do it through education and motivational feedback.

At a policy level, comments made included references to 'the voice of nursing' in public. It was said that this 'voice' has become a 'constant whine' about monetary and status issues *(Policy, I014, 480-485)*. Policy participants in this research also spoke about the dearth of leadership in nursing management, commenting that "*Nurse management at the moment is poorly organised … the best organised element of nursing at the moment is the INO and SIPTU and the PNA*[32]*… but I would see from my desk that they have adopted a very negative role. (Policy, I025, 420-425)*. This could be contrasted with the ideas expressed by Buresh and Gordon on the importance of *The Voice of Nursing* in their book *From Silence to Voice – What Nurses Know and Must Communicate to the Public* (Buresh & Gordon, 2000).

Medical consultants also speak about their frustration at introducing change and being suspected of *"trying to off-load work" (Medical Consultant, I021, 857-862)*. Medical consultants also commented on the fact that nursing is frequently 'driven by union concerns' and that this was not helping the profession.

Nursing and midwifery will be facing increased demands to adapt to change as a result of the recommendations made on the resolution of the industrial dispute that took place in 2007. The dispute, which lasted 7 weeks, was principally about the reduction of the working week for nurses and midwives from the current 39 hours per week to 35 hours per week. The dispute concluded with a recommendation that a phased approach would be taken to the reduction in working hours (HSE Health Matters, 2007g). Phase 1 entailed the reduction in hours to 37.5 by 1st June 2008. Phase 2 involved the setting up of a Commission, composed of two international experts, with specific expertise in

[32] The three principal Unions representing nursing and midwifery are The Irish Nurses Organisation (INO), Service Industries Professional and Technical Union (SIPTU) and the Psychiatric Nurses Association (PNA)

nursing management, and two representatives to be appointed following consultation with the HSE and the Trade Unions. The Commission would examine the feasibility of reducing the working week to 35 hours. Both Phase 1 and Phase 2 will entail changes in roles and working practices for nurses and midwives. For Phase 1, local discussions are to be held to identify ways of achieving efficiencies through the introduction of more efficient roster arrangements, relocation / redeployment / replacement and achieving efficiencies through skill mix. For Phase 2, the Commission will examine international experience of best practice in the activities and deployment of nurses and midwives and the type of flexibilities and changes that would be necessary to achieve a 35 hour week. In the meantime the HSE is to conduct its own feasibility study, which will be submitted to the Commission for consideration. It is clear therefore that the move towards a 35 hour week will entail significant changes in work practices for nurses and midwives.

6.4 Leadership

The third category identified under the theme 'The Changing Role for Nurses and Midwives in Ireland', was leadership (LE). A total of three codes were included under the category LE. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 6.3 Codes, Definitions, Frequencies – Leadership

Code	Definition	Frequency
RCLENL	There is a great need for leaders to emerge from within nursing and midwifery.	125
RCLEEM	Empowerment is an important dimension in role change.	20
RCLEAS	Nurses need to learn to be more assertive in their relationships with Medical Consultants and others within the services.	51
RCLENM	There are a number of issues arising in relation to the involvement of nurses and midwives in management, including the general management of services and the management of nursing and midwifery.	52
	Total	248

A total of 248 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided.

The code RCLENL, which captures participants' comments on the need for leadership within nursing[33], was the second most frequently used code throughout the whole of this research[34]. That in itself is a testament to the importance that participants gave to this issue. It is perhaps even more interesting given that there was no probe used in Question 4 (6.1) on this issue. It was raised spontaneously by participants in the research. The other segments relate to the issue of empowerment of nurses and midwives (20), the need for nurses and midwives to be more assertive in their relationships with Medical Consultants and other professionals and administrators within the services (51) and the need for nursing and midwifery to exert a greater leadership role in the general management of the services (52).

Both policy and service participants in this research express the opinion that nursing management has not stepped up to the mark in the way that it was hoped they would after the Commission on Nursing. There is also evidence that nurse managers themselves feel let down by the outcome of the recommendations of the Commission, ending up more isolated in their role as managers and still not integrated into the key decision making mechanisms.[35]

From the service point of view, nurses are seen as not being assertive enough:

> *Nurse managers need to be pushing their way in management and putting their hand up and saying 'look we have experience of the business that nobody else can*

[33] See discussion on leadership in nursing in Ireland in chapter 3 (3.8.3)

[34] The most frequently used code was FHACAL – accountability at all levels will be a major feature of the future of health services in Ireland (5.7) with 135 occurrences.

[35] See discussion of leadership and empowerment in chapter 3 (3.3)

match' … I think to a large extent that nurses aren't as assertive in those areas of management as they should be and as befits their experience. (Policy, I002, 1110 … 1146)

There appears still to be confusion about the role of the Director of nursing – is it strategic? What about the operational side? What is the role of the Assistant Director of Nursing (ADON) and CNM III? There appears to be a lack of understanding and of support for, in particular, the important role of the Assistant Director of Nursing and CNMIII. As a result there is confusion about applying for such posts and there is a lack of support for those who hold them and those who aspire to them *(Service, I006, 406-436)*.

Participants frequently made reference to the management structure for nursing and midwifery that has been in place since the Commission on Nursing, with many of them voicing concerns about the lack of clarity of the roles and the increasing complexity of management structures that have emerged. For that reason it might be useful at this stage to consider what it was that the Commission on Nursing actually said about this important point.

In relation to the role of the Director of Nursing, the Report of the Commission on Nursing was quite explicit: *"The responsibilities of senior nursing and midwifery management should include providing strategic and clinical leadership and direction for nursing and midwifery and related services which results in the delivery of effective, efficient, quality assured and patient centred nursing and midwifery care"* (Government of Ireland, 1998). It is clear from this statement therefore that the intention of the Commission was that the role should be strategic and should extend beyond nursing into related services. It was for that reason that it recommended that all Matrons in large acute hospitals and chief nursing officers in the psychiatric services should be entitled Directors of Nursing. In relation to the role of the Matron in smaller hospitals (Bands 3, 4 and 5) no recommendation was made on a change of title. It was recommended however that these Matrons need to combine a professional leadership role with detailed general management responsibilities (Government of Ireland, 1998). In recognition of the fact that Matrons of smaller hospitals had

traditionally not been involved in the budgetary process, it was recommended that in order to discharge their general management functions more effectively, they should be given more explicit input into the determination of the budget and greater control and responsibility over its utilisation.

In relation to the role of middle management in nursing, i.e. including what had been referred to as Assistant Director of Nursing, Directorate Nurse Manager, Unit / Divisional Nurse Manager, Night Superintendent, Assistant Matrons, the Commission on Nursing also made a series of recommendations. In particular the Commission recommended that these grades should have a clearly defined management role, in the absence of which they become limited to carrying out merely administrative duties (referred to by the Commission as "gatekeeping functions") which bear little relationship to professional nursing or midwifery. The Commission also recommended that greater nursing input should be provided for in areas that impact directly on the quality of care, such as laundry, catering and cleaning, and nursing management should be involved in discussions on the award of contracts for such services (Government of Ireland, 1998). The Commission also recognised that a lot of work had already taken place in this area with the development of Directorate or Service Management models, involving clinicians, including nurses, directly in the management of services. In the Directorate system nursing and midwifery managers have devolved authority in relation to the leadership and development of nursing and midwifery personnel within the Directorate.

In relation to front line management, the Commission on Nursing was very explicit about the role of the Ward Sister, which was referred to as "*the lynchpin"* in the services. The recommendations of the Commission on front line management included their involvement in professional / clinical leadership, staffing and staff development, resource management and facilitating communication. These roles imply that they should have greater budget responsibility in relation to the utilisation of resources at unit level. The Commission recommended that that front line management should consist of three grades of Clinical Nurse Manager. It recommended that the Ward Sister should be referred to as Clinical Nurse Manager 2 (CNM2) and the junior ward

sister should be referred to as CNM1. The Commission recognised the need for the CNM1 post in ward conditions that were particularly complex. The CNM1 should take charge in the absence of the CNM2 (Ward Sister). The Commission also recommended that in particularly complex institutional settings there might be a need for a grade of CNM3, above that of CNM2 – examples of this include A&E in a large tertiary acute hospital where there would be a requirement for a number of CNM2s and the CNM3 would be designated as being in charge of the unit (Government of Ireland, 1998).

Participants in this research spoke about the important role that educators can have in influencing thinking within nursing about the meaning and implications of leadership / accountability / responsibility. Participants felt that educators should be influencing the career development of students as they come into the system, but they should also be working with more senior personnel in preparing them for their roles as innovative accountable leaders *(Service, I006, 436-463)*.

An important function of nurse leaders is acting as advocates for nursing staff. In the absence of good leadership from nurse management, nurses and midwives are turning to their staff associations / unions for leadership and advocacy on their behalf *(Service, I006, 463-476)*. The lack of leadership in nursing is articulated by service managers as a lack of advocacy on behalf of nursing, making strong statements about how nursing should position itself within the services.

> *I do not see leaders in the nursing profession in the way that you do in the medical profession for example. I think there is an issue there. I don't know what the reason for that is … It seems to me that nursing is quite passive in terms of setting the vision for nursing for the future … that nursing leadership are not setting out the vision for nursing into the future … It seems to me that nursing leadership in this country should be taking that debate forward in the interests*

of the nursing profession … (Service, I012, Extracts: 185…441)

The same participant went on to express the hope that nursing and midwifery would produce leaders who would analyse the environment, understand the changes and make strong statements about how nursing and midwifery should be positioned within it, in cooperation with but not deferring to the medical profession and not waiting for the leadership to come from the unions *(Service, I012, Extracts: 185…441)*. This gives rise to the situation that the only leadership that is prominent in nursing is frequently industrial relations orientated, leaving a major gap in the development of the profession. This echoes the views already discussed (6.4) about resistance to change.

The kind of leadership that is needed must emerge from within nursing itself and it should be coordinated between nursing management, nursing academics and other nurse leaders, and linked to other functions. This kind of integrated planning for leadership is not happening at present:

I think it needs to fundamentally begin with nurses and I think that leadership of nursing needs to be given by nurses. I have no doubt at all about that and there needs to be close linkages between the academic units and the senior management units and that there needs to be collaboration at the academic units between the nursing schools and medical schools and between the management side. (Service, I008, 420-430)

This idea is echoed by the Directors of Nursing and Midwifery who participated in the focus groups. They spoke about the need for nursing management to change and become more strategic and that if this change did not happen they would be left in 'little pockets':

I think nursing will not develop unless we lead the change and I think it will remain stagnant unless we are looking at

> *very innovative ways of trying to create that seamless service that we feel is going to be missing in the new structures. I think we have to look and see how we can develop specialization on maybe a shared basis between acute and community services so that we are looking at ANP going out maybe for example, looking at the elderly, that they are not hospital based, they are not community based but they are a shared responsibility, that they are looking at a specialist service throughout at region as opposed to just focused in a hospital, that maybe they can look at on a population basis what the needs are as opposed to just on the actual acute or community service basis so I think unless we are looking at that strategically, and in a much broader basis than what we are doing currently, we will be just left in the little pockets we are in (Directors N&M, FG01)*

When meetings are being organised by one part of the nursing profession, very often it is done without adequately informing or involving the other. One participant in education said *"I find it amazing that for example the directors of the NMPDUs would be having meetings with the directors of nursing and not automatically include the HEIs"*. The same participant tried to explain why that might be: *" part of the reason for that is that … nursing in universities is still seen as … purveyors of courses rather than people who understand anything about the health service or who can feed into it in terms of research or ideas or a think-tank kind of set up" (I044, Education, 2166-2205)*.

There is an idea in this text of a 'think tank for nursing', involving all of the key stakeholders and providing the opportunity for inputs from the various nursing areas (clinical, management, education, professional development, regulation) into the formulation of a vision for nursing – taking the lead in providing the leadership that is being called for. This is required despite the fact that frequently there is a sense that people feel *'swamped'*. This is the case for example in educational circles where all of the effort in recent years has been

directed towards setting up the degree programmes and post graduate programmes that have been needed to implement the recommendations of the Commission on Nursing.

This raises the question about the relationships between the different elements involved in nursing throughout the service. Relationships are not always easy and in the case of the relationships between the Directors of Nursing and the NMPDUs there is work to be done in clarifying the way in which they work together:

> *The relationship between the NMPDUs and the directors of nursing is a difficult one and I think that if we can manage to resolve that that we can help to empower them a little bit more. (Service, I076, 732-737)*

It also raises questions about the relationships between the different groups of nurse managers, between the directors of nursing in Band 1 Hospitals through to Band 5 Hospitals, and between the various levels of nurse management, i.e. between Directors of Nursing and other nursing management grades (CNMI, CNMII, CNMIII and assistant directors of nursing). There is evidence to suggest that divisions exist between the Bands and the grades that are not serving the purposes of the profession well. Participants spoke about an elitism and a hierarchy within nursing, whereby directors of Band 1 hospitals saw themselves as being at the top of the pyramid and would occasionally involve directors of nursing from Band 2 hospitals, but would never have anything to do with directors of nursing from Bands 3, 4 and 5. Similarly, directors of nursing and their associations[36] will not engage directly with the associations of other nurse managers. This was expressed by one participant as:

[36] The Association of Irish Nurse Managers (AINM), now known as The Irish Association of Directors of Nursing and Midwifery (IADNAM). ENTRUST is the association of clinical nurse managers at CNMI, CNMII, CNMIII.

> *There is no unifying structure even where they could come together as a federation of nurse managers and say look we as nurse managers play a huge role in keeping this show on the road we are not always listened to we don't get our hands on lots of the budgets and we should draw up an agenda to make sure that we are in there at the table. (Policy, I025, 505-532)*.

The suggestion is that there is a need for a more united front, more strategic coordination, from nursing management that is different from the industrial relations based negotiations that take place. The creation of a unified approach on behalf of nurse management as a negotiation force is something that will require the breaking down of silos within the profession *(Policy, I025, 564-569)*.

An opinion expressed by some of the service managers who participated in this research was that the Commission on Nursing left nursing management a bit isolated within the services. It did not tackle the question of integrating it into the wider decision making structures within the services. A more concerted, coordinated approach to articulating the 'nursing voice' in a manner that lifts it beyond just the nursing dimension and takes account of the wider issues within the services, is one way in which this could be tackled *(Service, I036, 277-312)*.

The strategic voice of nursing is not being heard in the way that it was envisaged that it should by the Commission on Nursing, across a multi-disciplinary range of areas. This was articulated by one participant as

> *I don't see a strategic sense of influence within the department. I see an awful lot of excellent good work done … but I don't see a very strong policy influence in terms of the multi-disciplinary health service as opposed to the nursing one … they have not played their part as I think was envisaged that they would almost be part of the broader influencing of a strategic approach to the health services from a multi-disciplinary point of view. Now maybe*

> *they were not allowed to do it or maybe there was not an acceptance again by virtue of where it came from in terms of the idea being put into place. I am not sure that they are at the table other than at the IR area of nursing. (Service, I036, 355-383)*

The previous text reflects a view from within the participants in this research that the strategic role of the policy unit within the DoHC is not being felt within the profession or within the health services generally. There does however appear to be a commitment to the continued role of for a nursing policy unit within the Department of Health *(Policy, I031, 739-774)*. The role of the Chief Nurse within the Department of Health requires, according to a number of the participants to be re-defined, particularly in the light of the changes that have taken place within the HSE, the role of the DoHC, and the recent creation of a nursing unit within the HR division of the HSE. There is also, in the opinion of a number of participants, a need to agree what role, if any, nursing advisors should have within this structure.

It is worth mentioning in this context a *European Delphi Study* (WHO, 2001), which identified the ideal attributes of a Chief Nurse. These include: communication, team working, strategic thinking, professional credibility, leadership, political astuteness, decency / integrity, innovation, decision making / problem solving, personal qualities, promotion of nursing, good management and conflict resolution, information handling, research skills and physical characteristics. The study was conducted as part of an initiative to advance the role of the Chief Nurse in member countries of the WHO Europe. It concluded that in order to advance the role it is necessary to engage in a systematic selection of suitable and recruitment of suitable post holders and introduce a critical pathway for development both of new recruits and existing personnel. The identification of the key attributes was intended to support this process (WHO, 2001).

There is a broader concern about the level of clinical representation at the highest level within the HSE. It just so happens that the current Chief Executive

of the HSE is a clinical person, but there are no provisions with the structures that are envisaged within the *Prospectus Report* (DoHC, 2003b) for a clinical person at the highest level *(Education, I044, 722-754)*. Participants spoke about the need for a clinical voice at the top decision making table and regretted that it was not a requirement that this should be the case in the new structures.

In relation to the broader role of nurses in the management of the services, a number of participants expressed the view that it was difficult to identify nurse managers who are capable of moving beyond the bounds of nursing itself and taking on board the broader demands of executive functions across the whole hospital. There are some good examples of this but not enough, and it is often a question of preparing them for that role, a preparation that does not exist at the moment. One of the participants spoke about the need for directors of nursing to consider their broader corporate presence within the organisation:

> *When I look at a Director of Nursing she is the Director of Nursing but when you are directing a hospital like this you really are a senior executive of a hospital at a board level and at every level." (Service, I022, 501-540)*.

There is an idea of an 'executive nurse' rather than just a 'director of nursing' that says something about the wider role that nursing needs to have within the services:

> *To me it is about moving to a situation whereby we develop executive nurses rather than directors of nursing and it is that executive leadership that nurses must become more proactively involved in. (Director NMPDU, I050, 418-423)*

It is not enough that nurse managers are good at managing nursing; they need to be able to expand beyond the borders of the profession to present the nursing voice at the wider executive table:

> *They can perform very effectively in their own arena and I would suggest that their own arena does not provide enough of a challenge for them once they get to that point. I think we need to face some of our nurse leaders with the fact that that simply is not enough. That is simply not enough that is not what you are doing your MBA for. It is not what you are doing your doctorate for. It is not why you get to be director of nursing in the big large teaching hospitals. You are there because you have to be sufficiently confident to know that you can perform well beyond that arena. (Education, I044, 1019-1045)*

This failure to reach out beyond the immediate boundaries of nursing may be due to an in-built culture of passivity within the profession that needs to be named and tackled *(Education, I044, 847-872)*.

Ultimately this is about positioning Directors of Nursing within the decision making structures in the services. It differs from one hospital to another and from one setting to another, but it is an integral part of the clinicians in leadership approach that is being developed within the HSE and that in turn builds on the clinicians in management initiative (OHM, 1998 & 2003d) that has been developed over the last number of years *(Service, I076, 751-761)*.

The directors of nursing who participated in the focus groups spoke about the difficulty of making the voice of nursing heard at the decision making table within the executive structure in the hospital *(Directors N&M, FG01)* and commented on the need for them to be involved in developing and shaping the services of the future, otherwise they will be left behind. This will involve positioning the role of the director of nursing more clearly within the system and ensuring that reporting relationships and duties are clearly understood. One participant spoke about a director of nursing being asked to report to a much lower administrative grade and that there was evidence within the system that this was not unique *(Service, I076, 769-781)*.

The directors of nursing and midwifery who participated in this research, however, were very clear about the ability, competence and levels of education that existed within their group to enable them to take their place 'at the table'. Nurses are a very experienced, versatile and, increasingly, well educated group, with many of them now possessing post graduate qualifications in a wide range of management disciplines:

> *but we… need to get that recognised in some way in this new structure… and get those nurses into the different change management teams that will be out there leading the change. (Directors N&M, FG01)*.

Directors of the NMPDUs who participated in this research pointed to the difficulty that many institutions are experiencing in recruiting senior nurse managers. This is something that is leaving significant gaps at senior level within the profession and is evidence that there is an unwillingness to take on these challenges. They spoke also about the possibility of introducing mentoring services to encourage the development and advancement of the leaders of the future *(Director NMPDU, I026, 922-944)*. Nursing is seen as not investing in its own future, mentoring and bring on the next batch of senior managers because of its preoccupation with micro management of services, and it is not surprising, therefore, that people are not applying for senior posts as they become vacant. This is a theme that is taken up by more than one director of NMPDU *(Director NMPDU, I041, 845-875)*.

As newer opportunities have emerged because of the opening up of a wider range of career pathways, there are more and more attractive clinical options open to nurses and midwives than there were before. It had always been the lament of nurses and midwives that the only paths forward for them lay in either management or education. That is not the case anymore and it has created a challenge in the area of nurse management that had not been anticipated. Nurse educators also voiced this opinion: "*I am concerned in those very senior posts that people are not competing for them, that there really are issues about bringing people into management". (Education, I055, 315-332)*. Participants felt

that the role is not seen as attractive and that the problem is also related to a lack of identity for the grade of nurse management below that of Director of Nursing. It seems clear that people at assistant director of nursing level have a crisis of identity about their role and their future.

> *It is disappointing to hear young very energised very well educated assistant directors wanting out of their jobs and… asking you where the opportunities are or should I go for this or should I go for that? Which you could see as a sideline move … but they are not seeing … applying for the top job as being as attractive as it should be. (Education, I045, 418-434)*

This raises the important question about support for nurse managers, nurse leaders and echoes points raised in some of the earlier texts about clarity of role for the assistant directors and support for them in that role. It raises the whole question of management development and succession planning within the profession and in particular within the management structures of the profession *(Director NMPDU, I009, 1099-1109)*.

6.5 Nurse / Midwife-Led Services

The fourth category identified under the theme 'The Changing Role for Nurses and Midwives in Ireland', was Nurse / Midwife-Led services (NL). Two codes were included under the category NL. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 6.4 Codes, Definitions, Frequencies – Nurse / Midwife Led Services

Code	Definition	Frequency
RCNLCR	It is important that the coordinating role of nurses and midwives in clinical settings is understood and appreciated more.	14

RCNLCS	There will be an increase in the amount of Nurse / Midwife Led clinical services.	56
	Total	70

A total of 70 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided.

The role of the nurse as coordinator[37] of both clinical and management / logistics services within the clinical setting was one that was highlighted by a good number of participants in the research (14) without any prompting by the interviewer. The concept was not included as part of the probes used for Question 4 (6.1). Most of the participants (56) chose to comment on the issue of Nurse / Midwife Led services, which was one of the probes used for Question 4 (6.1), and there was universal agreement on both the need for increased Nurse / Midwife Led services and the fact that they will increasingly become a feature of future health services.

In relation to the coordinating role of nurses and midwives one simple statement encapsulates the views of most of the participants on this:

> *I think nurses have a lot of skills and are eminently good coordinators. They spend at least 50% of their time coordinating. They spend an awful lot of their time liaising with other people. (Education, I044, 1952-1960)*

Additional comments referred to the fact that within clinical settings, nurses are there all the time. Doctors, physiotherapists, occupational therapists, dieticians and other service providers come and go, but nurses provide a twenty-four-hours-a-day, seven-days-a-week service in the area. The shift system, and the 'Unit Nursing Officer' / Ward Sister / CNM role makes them eminently suitable

[37] See discussion on nurse led services in chapter 3 (3.3.5)

for this role of coordination of the inputs and services of all other service providers. They are also intimately involved in managing the logistics of the clinical setting and are therefore well suited to a broader general management role within the setting. One participant expressed this in an interesting way:

> *They are kind of the glue and I am just a bit worried that… because there is such specialisation, they may not be the glue anymore. (Service, I022, 832-836)*

This concern that the move towards increased specialisation of roles within nursing, with CNS/CMS and ANP/AMP, could detract from this overall coordinating role of the nurse is one that found echo in a number of participants. The earlier discussion about clinical career pathways (6.3) covered some of these concerns and emphasised the need for continued support for the generalist role of the nurse, as someone within the clinical area who, at the end of the day, knows who to call in when a crisis arises (6.3). It was pointed out in the earlier discussion that the role of the CNS/CMS and ANP/AMP does provide the general nurse / midwife with significant additional support.

This coordinating role however is particularly important when one looks at the role of the ward sister or CNM2:

> *They are strong on things like clinical audit, team work. You look at ward sisters and their main role is to coordinate the functions on a medical or surgical ward … so they are used to dealing with the different disciplines… I would see the CNM2s as being the most skilled people on wards because they organise care. (Director NMPDU, Extracts 181…552)*

What is emerging from these texts is the concept of the general nurse/midwife, and in particular the unit / ward manager – ward sister, CNM2 – as the coordinator of a wide range of services within the clinical setting and the organiser of care. This is a role that requires a complex range of skills and understanding and the ability to deal with all of the disciplines. This is a vision

of nursing that permeates many of the responses from participants in this research and is to be found underlying many of the comments that are made on a wide range of topics. It is therefore a central concept in the role of the nurse/midwife. It is also something that is distinct from the role of the specialist nurse/midwife, and one that is eminently complimented by the specialist role. Specialist nurses/midwives are in a position to provide a wide ranging support to general nurses/midwives in clinical areas along with the many other advantages we have already discussed (6.4)

The idea of nurses/midwives as coordinator of services and the emergence of increased specialisation of services naturally leads on to the idea of Nurse / Midwife Led services. This was a topic that attracted a large number of comments (56) with very little probing. There was universal agreement that it was inevitable that there would be a significant increase in the amount and variety of Nurse / Midwife Led services in the future and that this was also desirable.

Medical consultants who participated in this research showed no hesitation in advocating an increase in the range of nurse / midwife-led services. Frequently the reference to the role of the CNSs / CMSs and ANPs / AMPs included also a reference to the importance of the work of the National Council in facilitating and encouraging the development of these roles within frameworks of practice.

Midwifery has in fact played quite a lead role in the provision of nurse / midwife-led services. This was referred to a number of times by participants. The following comment by a medical consultant sums up the views of many:

> *Already in this institution for example we have set up a … home birth service which is run totally by the midwives and indeed we have had directly led midwifery services and midwife clinics now for 20 years. (Medical Consultant, I024, 149-158)*

One medical consultant referred to the idea of *'devolvement of normal healthy pregnant women to midwives' (Medical Consultant, I024, 157-158)*. This raises the general idea of referrals to nurses and midwives as a feature of nurse / midwife-led services. This was an idea that was raised by a number of participants in this research. It is something that would appear to be particularly attractive in both primary and acute settings for a wide range of health issues and across all of the divisions of nursing *(Service, I057, 174-184)*.

The idea of nurses acting autonomously within primary care settings, taking referrals from GPs and referring on to medical consultants and other professionals where necessary, or acute services generally is one that sat quite comfortably with participants in this research, and one that emerged with no prompting. One participant referred to the emergence of "*a general nurse practitioner in the same way that you have a general practitioner in medicine"*. The participant went on to comment that *"they would have their own clinics; they would have their own surgeries; they would have their own service day units and so on… (Director NMPDU, I050, 405-413)*.

The concept of nurse/midwife led services is one that arises also in the next sections of this chapter on interdisciplinary teams (6.6) and the development of relationships between primary and acute care settings (6.7). It is worth reflecting however on the fact that it is not a new concept in healthcare[38].

6.6 Interdisciplinary Teams

The fifth category identified under the theme 'The Changing Role for Nurses and Midwives in Ireland', was interdisciplinary teams (IT). One code was included under the category IT. The following table provides a definition of the code used and an indication of the frequency of the occurrence of the code within the texts.

[38] See discussion on *The NHS Plan: A Plan for Investment, A Plan for Reform (DoH, 2000) in chapter 1 (1.3.2)*

Table 6.5 Codes, Definitions, Frequencies – Interdisciplinary Teams

Code	Definition	Frequency
RCITII	There will be an increased involvement of nurses and midwives in interdisciplinary teams.	54
	Total	54

A total of 54 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided.

The desirability of nurses/midwives to work as part of interdisciplinary teams was a topic that came up under a number of different themes and categories. We have already made reference to it in the section on clinical career pathways (6.3), leadership (6.5), and Nurse / Midwife Led services (6.6). We also made reference to it under a number of the categories within the theme 'The Future of the Health Services' (Chapter 5). The issue was raised in those questions without any probing by the interviewer. Participants chose to link the question of interdisciplinary team working to the issues raised under those categories and codes.

The question of interdisciplinary team working was one of the probes in question 4, and most of the participants chose to address it (54). All of the participants who chose to address the topic agreed that it was both desirable and inevitable that nurses and midwives would find themselves in the future working more and more in multidisciplinary and interdisciplinary teams.

In many of the interventions the comments centred on the importance of nursing developing the confidence to participate in these teams and to assert the nursing voice as an equal member of the team. Many of them referred to the fact that there was still a lack of confidence in this area:

> *It's getting better but they almost felt they had to be spoken to rather than speaking out themselves and they didn't see*

themselves as equal even within the multi-disciplinary teams. (Service, I015, 780-786)

Reference was made to the fact that nursing, through education and practice, was becoming more self-confident. They are emerging as the profession that is *'with the client'*, '*at the front line and in touch with the realities of patients and clients' needs'*, and '*in possession of the necessary skills to assess and address these needs'*. The value of education in increasing this confidence and ability to take part as an equal in these teams was a point that was raised by many participants. In acute settings involved in the hospital accreditation process, it was commented that *"Where you are seeing the change is in places with the accreditation where there are multi disciplinary teams - the nursing voice is starting to rise. (Service, I043, 1050-1053)*.

The discussion on primary services and the likelihood of nurses and midwives providing a wider range of nurse and midwife midwifery led services in primary settings usually drew comments about the importance of multi-disciplinary team working. The reality of multi-disciplinary working is seen as a natural corollary of nurses and midwives providing more Nurse / Midwife Led services.

Participants commented that nursing and midwifery should not see itself as the 'Cinderella' of the multi-disciplinary team but as having a vital and central role to play in it. There were comments from nurse leaders that they had a responsibility to go out and promote this concept:

There is an onus on us all as nurse leaders to go out there and support mechanisms to help that to happen. (Director NMPDU, I049, 168-171).

This need to promote the role of nursing and midwifery within the team is related to the fact that traditionally medical consultants have seen themselves as the natural leaders of the interdisciplinary team. That is something that participants see as changing over time, but it will require a change of culture. This change of culture is something that will be greatly helped by changes in the education

and training of nurses and midwives over time. This will however require nurses and midwives to move outside of their traditional comfort zone:

> *I see a problem of nurse leadership of leading other professions. I think they can lead within their own discipline but I think they can feel out of their own comfort zone when it is with other disciplines, so I think now with better education they can take an equal place at the table. (Service, I056, 290-298).*

The challenge of interdisciplinarity is not an easy one, as professionals are becoming more assertive in their own disciplines, including nursing and midwifery. This is something that was recognised by the Medical Consultants who participated in this research.

6.7 Relationships between Primary and Acute Care Services

The sixth category identified under the theme 'The Changing Role for Nurses and Midwives in Ireland', was relationships between primary and acute care services (PA). A total of two codes were included under the category PA. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 6.6 Codes, Definitions, Frequencies – Relationships between Primary and Acute Services

Code	Definition	Frequency
RCPAAC	Nurses from acute services will most likely get involved in follow-through services to clients in the community on their discharge from the acute services.	12
RCPANC	There is likely to be an increase in the numbers of nurses and midwives active in the community.	33
	Total	45

A total of 45 segments for this category, with the majority of them referring to an increase in the numbers of nurses and midwives who will be active in the

community, primary care settings (33), resulted from the probe used in question 4. The wider question of relations between primary and acute settings however has already arisen, without probes, under other categories within this research. The topic has been dealt with when we spoke about organisational changes within the health services of the future (5.5), about systems pressure within future health services (5.6), and in a number of categories within this chapter. It must be seen therefore as a central issue within this research. It is of course of particular relevance to the Transformation Programme (HSE, 2006b) that is at the core of the development priorities of the HSE for the period 2007 to 2010 and as discussed in chapter 5 (5.5). In addition, in 2006 the National Council produced a report entitled *Improving the Patient Journey: Understanding Integrated Care Pathways* (National Council, 2006f). This report emphasises the importance of integrated care pathways and provides guidance for nurses and midwives in implementing integrated care pathways. An essential feature of the implementation of integrated care pathways is the development of partnership and collaboration arrangements with the interdisciplinary teams across the continuum of care facilities.

There is evidence in this research that there is a commitment both at the policy level and at the executive level to build the services of the future around this central concept of a shift from acute to primary care services (5.5). It is also clear that nursing will have a central role to play in this. The policy commitment is to development in areas across the board. International best practice in this area is quoted by some of the participants in this research:

> *I understand in Paris there are over a thousand hospital nurses who work in the community on early discharge arrangements and I would like to see something like that happening in Dublin. (Policy, I025, 446-451)*

The approach is frequently associated with managing occupancy rates and early discharges that are made more feasible when nurses and midwives follow through with direct support to clients / patients in their own community settings. This is not without its difficulties, as the issue of industrial relations and the

cooperation of the unions for changes such as these is not underestimated, as one participant said *"they can contribute hugely in the community if we can get around the logistical and IR issues. But that is going to take time. (Policy, I058, 136-139)*

Trade Union representatives who took part in this research did state their commitment to the value of this approach, referring to the value it had in terms of job satisfaction and in the value it brought to the quality of patient care (I068 and I073). According to one of the participants, the experience, however, of the recent initiative Nursing and Midwives in the Community (NAMIC), would seem to suggest that in practice there is a lot of union opposition to the necessary changes that will be required to make it happen *(Service, I076, 474-483)*.

Within service management, as we have already seen when discussing organisational structures of future health services (5.5), the commitment is quite clear:

> *The first change we are going to see is that services are going to be moved out of hospitals so there is no point in nurses and doctors being left in hospitals to the degree that they presently are. They have got to follow where the patients are. (Service, I075, 211-216)*

Service managers are also clear that nurses and midwives have a clear role in this shift from primary to acute and in the creation of bridges between the two sides of the services. It has already been said (5.5) that the example of what has happened in the North East[39] is a model that will be made more widely the norm throughout the country. This model is based on a central role for ANP/AMPs and CNS/CMSs, working in the community and linking back into the acute services, working closely with GPs and other members of interdisciplinary teams. Indeed the expectation and the hope is that nurses and midwives should

[39] See *Review of Health Services in the North East* (Teamwork Management Services Ltd, 2006) and discussed in chapter 2 (2.3.1.2)

lead this shift in approach to service delivery. This may have implications for the configuration of local hospital services as *"that means our local hospital may only have GPs and ANPs. Now you could turn that on its head and say your local hospital will be much better off than it is at the moment. (Service, I075, 341-346)*.

The expectation therefore is that the quality of service provided at a local level should be significantly enhanced by this approach. An important dimension to this approach is the empowering of the patient / client to take responsibility for their own needs within their own setting. This is particularly true for people with chronic conditions such as diabetes for example:

> *So much could be done to have people with those conditions nursed at home and I don't even want to emphasise nursed but empowered to manage their own conditions almost in a very proactive way in the environment that they wish. (Director NMPDU, I049, 141-148)*

Of course it is not possible to talk about nursing in the community without talking about the role of the PHN. This is a role that came in for a good deal of criticism within this research. The participants felt that the role was not well defined, either as a generalist role or as a specialist role, and that it was not clear what development priorities had been identified for it. There was also a good deal of criticism for the way in which the role of the public health nurse has been managed, with evidence of a considerable amount of resistance to change not being tackled by management. Some of the participants also referred to an increasing fragmentation in the way in which nursing and midwifery services are being delivered within the community, with no clear definition of the relative complementarity of the roles of the staff nurse/midwife, the public health nurse and the CNS/CMSs, ANP/AMPs in the community. One suggestion is that the role of the public health nurse should become more policy and educational in focus, with more specialist nurses in the community supporting that role *(Education, I016, 44-52)*.

This suggestion is perhaps more in line with what was envisaged for this role by the Commission on Nursing (Government of Ireland, 1998), which saw the role of the director of public health nursing as a mirror within the community of the role of the director of nursing within the acute sector. Each of these roles was intended by the Commission to be more strategic in nature, providing leadership to other grades of nursing.

The reality is that much is happening in primary care without any direct involvement of PHNs. Their role will therefore come under increased scrutiny as to their relevance:

> *If the profession is to survive in primary care in particular they will have to demonstrate that what they are doing is viable, that it is visible and is credible and I think that it wont be, I mean the public health nurses are a classic example at the moment you know I mean primary care is developing without them so then you have to say is what they are doing viable credible and is it visible. (Service, I076, 896-907)*

In September 2006 a report entitled *An Exploration of the Core Nursing Elements of Care provided by Registered General Nurses within the Community Setting* was produced by School of Nursing, Dublin City University (Scott et al, 2006). The study focused on identifying the core elements of nursing care deemed important for Community Registered General Nurses. There are at present 430 nurses (INO Database) whose primary role is to support the PHN in community care in Ireland (Government of Ireland, 1998). The report states that the Commission on Nursing had already raised concerns about the integration of the diverse range of nursing groups providing nursing services in the community and had stated that: *"There is a need for the profession to develop a coherent vision for the future direction of nursing in the community which reflects the nursing needs of the community rather than the status of individual groups within the profession*" (Government of Ireland, 1998).

This is the first substantial study on the role of the Registered General Nurse working in the community within Irish healthcare.[40]

6.8 Conclusion

One of the central aims identified for this research was: *"To identify the future role for nursing and midwifery within the Irish Health Services as perceived by key stakeholders within the services"* (3.2). Based on the primary research and the detailed review that has been conducted in this chapter, it is now possible to identify key elements of the future role of nursing and midwifery in Ireland as perceived by the stakeholders who took part in this research.

An overarching message that emerged from the primary research about the role is one of integration across the profession and a recognition that it is important to break down barriers between management, education, clinical practice, research and professional development. For that reason, in considering the future role and in identifying the elements that will be part of that role, an integrated approach is adopted. This involves looking at the overall profession and considering the constituent parts of the profession as mutually complementary and reinforcing, dispensing with any indication of hierarchical relationships between the various parts. This is a theme that will be returned to when we consider the strategy for the professional development of nursing and midwifery (i.e. the answer to question 13 in the objectives – (3.2)). With this in mind, the following points represent a summary of the key findings of the research in relation to the future role of nursing and midwifery:

1. It is time to review the rationale for maintaining five points of entry to the profession. The demands of the service and of patients and clients for increased integration and interdisciplinarity point to the need for the application of these principles to the way in which nurses and midwives are educated.

[40] See also information on the Community Intervention Teams in chapter 1 (1.3.2).

2. A Clinical Career Pathway should continue to exist and evolve in line with service and professional needs. This should define levels of practice. The levels of practice should include:

a. General Nurse / Midwife
b. CNS and CMS
c. ANP and AMP

3. A Management Career Pathway should continue to exist and evolve in line with service and professional needs. This pathway should change and adapt to service development requirements. It should include:

a. Front line management, i.e. Clinical Nurse Managers with a grading structure that matches the context of service delivery.
b. Middle management, i.e. Assistant Directors of Nursing, Divisional Nurse Managers, in accordance with the requirements of the service delivery context.
c. Senior management, i.e. Directors of Nursing.

4. Opportunities for the development of career pathways in other areas (education, research, professional development) should also be explored in order to provide a richer range of career options for nurses and midwives

5. Nursing and midwifery should operate on the basis of a primary / acute care continuum – nurses and midwives should move seamlessly between acute and primary care settings in line with the needs of the patients. The modalities of this should be agreed with health service managers and should be conducted in accordance with agreed protocols.

6. Nurses and midwives should play an active role in primary care teams. This should include where necessary, acting as leader of the team or as a member of the team with other professionals.

7. As part of their role within the primary / acute care continuum, nurses and midwives should continue to develop nurse and midwife led clinical

services. These services should be developed in consultation with health service managers and should reflect the levels of practice and the career pathway of the individual nurse / midwife. It should include as appropriate:

a. Management of case loads in both acute and community settings in accordance with agreed practice protocols and in line with their levels of practice
b. Management of early discharge from acute settings and follow up with the patient / client in the community, including where appropriate, in their own home.
c. Diagnosis of conditions in accordance with agreed practice protocols
d. Treating and prescribing in accordance with agreed practice protocols
e. Referring clients / patients to other areas of service delivery and other professionals in accordance with the needs of the patient / client
f. Taking referrals from other areas of the services and from other professionals in accordance with the needs of the patient / client
g. Education and empowerment of patients / clients in the community settings and in their own homes in the management of their own health.

8. Nurses and midwives should prescribe medications in accordance with the provisions of legislation and after having completed the required education and training programmes and achieved registration as a Registered Nurse Prescriber / Registered Midwife Prescriber with An Bord Altranais.

9. Nurses and midwives should act as members and, where appropriate, as leaders of interdisciplinary and multidisciplinary teams within acute and primary care settings.

10. Nurses and midwives should incorporate the role of healthcare assistants, home helps and other support staff into the delivery of their services as

appropriate in both acute and primary care services, and in line with agreed protocols and practice.

11. Nurses and midwives should continue to develop relationships with Medical Consultants, doctors and other health care professionals that reflect the development of their roles within their career pathways and in line with service needs. This should include identification of complementarity, development of an understanding of what each professional can bring to a multidisciplinary team, breaking down silos of practice and encouraging a culture of common decision making, collaborative working and multidisciplinary service delivery.

12. In acute care settings, nurse and midwife managers should have an input into areas of service management and delivery that affect the delivery of nursing and midwifery services. This should include involvement in bed management, where the role of nurses and midwives and their broad knowledge and understanding of the services, equips them to play a distinctive role. It should also include involvement in quality development initiatives where nurses and midwives have frequently taken a lead role. In addition it should include, where appropriate, control of and management of services of hygiene, laundry, catering and other logistical activities that affect the total quality of care for the patient / client in the acute care setting. The involvement of nurses and midwives in these areas should be agreed in accordance with management protocols developed at the local level in accordance with service and professional development needs.

13. Nurses and midwives should play an active role in engaging with the Clinicians in Leadership initiative. This initiative should build on the experience of models for the involvement of clinicians in management and leadership that have evolved in different care settings and should take account of the experience that has been developed through these models. Nurses and midwives should cooperate as part of a clinical management

team as either an active member or as leader depending on service and professional needs.

14. Nurses and midwives should play meaningful roles in both the strategic planning of health services within the HSE and the development of policies and performance management protocols within the DoHC. This should require nurses and midwives to demonstrate that they possess the competencies that are required to make a meaningful contribution at this level. It should also require the HSE and the Department to facilitate the involvement of competent nurses and midwives in this role.

15. The importance of the clinical voice at national level should be examined by the HSE, with a view to ensuring that at the level of National Director within the services this is guaranteed.

16. Nurses and midwives should explore with HSE management innovative approaches to the resolution of disputes without the need to have recourse to industrial action. This should involve maximum use of the partnership mechanisms that are already in place. Nurse and midwife staff associations and trade unions should continue to fulfil a key role on behalf of the profession within these partnership structures and as advocates of general conditions for nurses and midwives. The resolution of disputes should be conducted on the basis of respect for all parties to the dispute and for the role of nursing and midwife managers at local and regional level.

17. Nurses and midwives should incorporate the use of information and communications technology (ICT) into their practice within each of the career pathway in accordance with service and professional needs.

18. The role of nurses and midwives should expand in line with agreed frameworks for scope of practice. This should include a dynamic evolution of the role in line with service needs and professional development.

19. The role of nurses and midwives should evolve and develop in line with demographic and epidemiological trends and should respond to the need

for change in a proactive way, providing leadership within the profession in adapting to the needs of patients and clients within the services.

The next chapter in this research will explore the challenges of building the necessary skills and competencies that will be required to fulfil this role in the future health services.

Chapter 7 – Results and Discussion 3 – Building Skills and Competencies in Nursing and Midwifery to meet Future Challenges

7.1 Introduction

The interview schedule for the semi-structured interviews (Appendix 18) (4.7.1) devised as part of the methodology for the research, included a number of questions and probes to be used in the interviews. Five of the twelve questions referred to the skills required by nurses and midwives to meet the future challenges of the changing health services and on the education provisions designed to provide them with the necessary academic support in attaining and maintaining those skills. The questions and probes used are reproduced here for convenience:

Question 7 – What do you think are the key skills and competencies that nurses and midwives will need to develop to fulfil their role within the future health services?

Question 8 – In what way do these new skills differ from the present range of skills?

Probes for Questions 7 and 8:

Specialisation

Interdisciplinarity

Working in teams

Boundary spanning

Management

Research

People management

Communication

Financial skills

Question 9 – Do you believe that on the whole nurses and midwives already have these skills? (If no – why? If yes – are there any additional skills that will be needed?)

Probe for Question 9:
Appropriateness of education and training?

Question 11 – How would you assess the appropriateness of the current range of educational provisions for nurses and midwives in view of the changes ahead?

Probes for Question 11:
Aware of recent changes?
Pre-registration and post-registration
CPD?
Matched to needs?

Question 12 – What changes would you suggest in the provision of education and training for nurses and midwives?

Probes for Question 12:
Common basic education for clinical professionals?
Multidisciplinary
Broader basic education within the degree?

These five questions combined to provide a picture of the opinion of the interviewee on the skills required by nurses and midwives for the future health services – the third of the themes to be identified (SK), and on the educational requirements needed to prepare nurses and midwives for the challenges presented by those skill requirements – the fourth of the themes to be identified (ED).

These two themes combine to provide a view of the challenge of building skills and competencies in nursing and midwifery to meet future challenges. Within this general theme, a number of categories emerged based on the comments of the interviewees. These include:

Current skill levels (SC)
Differences from future skills requirements (SD)
Future skills required (SF)
Skill mix (SM)
Pre-registration education (PR)
Post-registration education (PE)
Common education (CD)
Continuing professional development (CP)
Joint appointments (JA)

These categories provide convenient headings under which we can analyse the individual codes that emerged under each of the categories. This chapter provides an analysis of the comments made by the interviewees under the theme and categories listed above.

7.2 Current Skill Levels

The first category discussed under the theme 'Building Skills and Competencies in Nursing and Midwifery', was current skill levels (SC). A total of two codes were included under the category SC. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 7.1 Codes, Definitions, Frequencies – Current Skill Levels

Code	Definition	Frequency
SKSCNN	Nurses and midwives currently possess the necessary skills to face the future challenges of a changing health service.	29
SKSCBC	A change in the skill levels of a small number of nurses and midwives can have a significant impact on the quality of care provided in a clinical setting.	36
	Total	65

A total of 65 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided[41].

It is worth pointing out that in the member checking exercise conducted as part of the verification of validity of the data (4.4), 60% of the respondents disagreed with the statement that nurses and midwives currently possessed the skills to face the future challenges of a changing health service. Despite this negative message from those who took part in the member checking exercise, it would be wrong to say that the overall tone of respondents to the levels of skills in nursing and midwifery was negative. Many were very positive and most recognised that things were changing fast and that everybody, not just nurses and midwives, had a lot of work to do to adapt and learn what was needed.

Almost all of those involved in the member checking exercise however (90%) agreed that a change in skill levels of a small number of nurses and midwives can have a significant impact on the quality of care provided in a clinical setting. This latter statement refers to what we called the bell-curve (BC) phenomenon, i.e. shifting some members of the group to the right of the probability distribution curve for skill levels within a clinical setting, resulting in a shift of the curve and a dramatic improvement in skill levels and in quality and safety[42]. This idea was suggested by one of the participants as follows:

> *I suppose … any group of people's skills are probably distributed according to the bell shape curve and you've got … the vast majority of people here in the middle … and the*

[41] The quotations provided are taken from the texts of the interviews and focus groups. They contain reference to the category of interviewee involved in the semi-structured interviews (Policy, Service, Medical Consultant, Education, Director NMPDU, Trade Union, Regulation), or participant in the focus groups (Directors of Nursing and Midwifery), the number of the interview / focus group and the line numbers within the transcribed / coded text.

[42] The use of the term 'bell curve' in this context is not intended to have any statistical validity in terms distribution patterns of skill levels but simply to illustrate the impact of changes within a group.

> *whole thrust of what we should be doing now in terms of the reform programme … is simply to move the bell curve to the right so that if you get a little bit of improvement in all of these people, things improve dramatically. (Policy, I002, 1450 … 1468)*

This idea found echo in quite a number of participants in the research, who spoke about the impact that education and training can have on the overall level of skills and on the quality of care that is delivered in a clinical setting. One participant, who felt that nurses and midwives in general did not possess the skills to equip them for the challenges of the future, referred to the importance of constantly assessing and evaluating the roles of nurses and midwives within the clinical setting as a complement to what is done in terms of education and training. This idea of *'looking at your own role'*, critically assessing and evaluating your own role, is something that was perceived by this participant as a new and welcome phenomenon in nursing and midwifery, something that had not been happening in the past:

> *No they don't have them but we are getting there, through education and the fact that they have looked at their own role, but they have got to more critically look at it, they have all the time got to look at their role on an evolving basis, and that's what they weren't doing, you have to constantly look, and we all have to look at our roles. (Service, I015, 919-928)*

A number of participants spoke about the impact that education was having on the profession but also pointed out that there was still a very large cohort of nurses and midwives who have been in the system for a long time and have probably had very little development. These represent the large bulk of nurses and midwives who *'gravitate towards hands-on patients' concerns' (Service, I053, 376),* who *'focus on individual patients and individual clinical skills'*

(Regulation, I061, 290), who '*have worked in county hospitals…busy taking care of the elderly… haven't got the time off' (Education, I016, 955…962)*.

A number of participants praised the work that the National Council, the NMPDUs and the CNEs were doing, but spoke about the need for scale interventions to make a greater impact and about the need for nursing and midwifery to be more *'aggressive in forcing training and demanding time and locums for people to be developed and skilled' (Service, I053, 399-412)*.

Participants spoke about the need to build an understanding that we are moving away from a delivery system that *'focuses on individual patients and individual clinical skills to a community or family based set of skills' (Regulation, I061, 290),* and that these skills were emerging and beginning to be developed well. This idea was expressed by another participant like this:

> *These skills need to be nurtured more, and I think there needs to be a realisation that we are moving away from an autonomous delivery to a more collaborative approach in terms of service delivery and that is where our challenge will be. (Service, I064, 300-307)*

This means that, as another participant put it, '*the hierarchical system may have been diluted'* and managers and clinicians *'have different relationships with each other and with the people that they are managing'*, but that *'it is still hard for people to step outside of that because it takes a long time' (Education, I072, 610…619)*. It is this idea of a new set of relationships between everybody involved in service management and service delivery that emerges as a key characteristic of the services of the future and therefore a key determinant of the skill sets that are required.

Other participants spoke about the need for people to learn by exposure to good practice, by experiencing what it feels like, for example, to work in a multi-disciplinary team environment:

> *I believe they don't actually understand what it means and in fact the only way you may educate people ultimately may be to arrange placements of students into teams that function well even for a week or two because I think that unless you actually see how a multidisciplinary team works well you can't actually understand it. (Service, I075, 738-746)*

There is therefore in all of this a core idea of the need for linkages between the clinical setting and education providers, including all those involved in the planning, accreditation, delivery and financing of professional development, continuing professional development and in-service education. Building skills for the future, building an understanding of what is needed for the future, and making an impact on a large cohort of nurses and midwives within the profession will be a collaborative venture across a range of different stakeholders and institutional settings.

7.3 Differences from Future Skills Requirements

The second category identified under the theme 'Building Skills and Competencies in Nursing and Midwifery', was differences from future skills requirements (SD). A total of two codes were included under the category SD. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 7.2 Codes, Definitions, Frequencies – Differences from Future Skills Requirements

Code	Definition	Frequency
SKSDCP	There is a need for continuity with the present coupled with the ability to prepare for and adapt to change.	48
SKSDSN	There are some specific skills that will be needed in the future.	77
	Total	125

A total of 125 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided.

When asked if they agreed that there was a difference between the levels of skills required now and those that will be required in the future (SD), 100% of those involved in the member checking exercise (4.10.4.2) said that they did agree. They all also agreed that there was a need for continuity with the present coupled with the ability to prepare for and adapt to change (CP). This idea is echoed in the 48 segments that emerged from the coding exercise. In addition, 77 segments emerged where, in response to some of the probes that were used, respondents chose to indicate what specific skills would be needed in the future.

When expressing themselves about the difference between the skills of today and those of the future, participants constantly came back to terms like '*taking more responsibility'*, *'being more accountable'*, *'more autonomy'*, *'more decision making'*. They also constantly refer to the fact that there will be more multidisciplinary and interdisciplinary working, more community based services with consequent implications for educational and training programmes. Another topic that comes up very frequently is that of *confidence* – the importance of nursing and midwifery having the confidence to take its place as an equal member of the team, to lead the team where needed and to articulate its opinion, ensure that it is heard.

The growing importance of primary care as a central theme in looking at the health services of the future has reverberated throughout all of this research. It is articulated in the context of the skills and competencies needed for the future and the implications this has for the kind of programmes we develop:

> *We are producing nurses now that in 5 to 10 years time, 80 or 75% of them in fact are going to be community roles …*

our educational focus should be shifting to take that into account (Education, I044, 495-500)

This means breaking down what has been referred to on a number of occasions throughout this research as '*the silo approach'* to service delivery, moving towards a more outward looking interdisciplinary approach and *'a willingness to take on board the attitudes and the skills that are necessary to accommodate that way of doing work' (Policy, I002, 1414…1425)*. This idea, along with the importance of a shift to primary care and community based services, are two of the key mantras throughout this research.

Participants spoke about the new role being '*more proactive, with greater degree of autonomy, which will also bring with it increased expectations' (Policy, I004, 142…146)*. One participant said that the current role '*is very much about delivering and doing. I think the next generation of nursing … is about leading, about autonomous practice' (Education, I051, 173…183)*. This implies taking on more responsibility, particularly, for example, in the area of nurse led clinics and in leading teams of service delivery (Service, I062, 230-243). The same participant went on to comment that the implication of this is that nurses and midwives will need a more rounded education and training for that role, one that encompasses training in skills that have not traditionally been part of the nurse education curriculum.

Some participants referred to the potential for nursing to occupy a central role in managing caseloads and case teams because of the versatility and flexibility of their experience. Medical consultants who participated in this research in particular expressed the view that nurses were ideally placed because of the breadth of their role. Many other roles within the clinical area (e.g. physiotherapists, occupational therapists, dieticians) had a very narrow focus, whereas nursing takes a greater degree of ownership of the overall clinical situation.

A related idea to this is the concept of the nurse in the community being capable of developing relationships with patients and clients to educate them and to

empower them to manage their own health. This requires the credibility *"to educate, negotiate, bargain, work with people in a way that no other professional can do*" (Education, I055, 363-377). This encourages a much more proactive approach from nursing to develop one-to-one relationships with patients in a way that no other professional can do, and this will become even more pronounced with the introduction of nurse prescribing (Service, I070, 152-159).This is a new way of working for nursing:

> *I think that in some ways nursing will be decision making, final port of call but with a lot of ANPs and not … having to have decisions signed off by other therapists or doctors. (Service, I075, 435-442)*

Many participants spoke of the need for nursing and midwifery to develop more confidence rather than more competence. They felt that the educational system that has been put in place and the opportunities for professional development that had been developed since the Commission on Nursing were the envy of many other countries and would produce very competent nurses:

> *In many ways we are the envy of a number of countries; we are the envy of the States, we are the envy of parts of the UK in terms of actually getting our degree programme. So we have come a long way in a very short time, after a long period of pretty much not a lot. (Education, I044, 927-935)*

The same participant however, went on to say that it is time to move beyond the Commission on Nursing now, have the confidence to move on:

> *I think the commission has done a lot in terms of a blueprint and ideas for the future etc but if we are actually going to move this profession, we have got to stand up and be counted and be willing to take the rough with the smooth, not rather hiding behind whoever and it is nice to have*

someone else to blame when it does not happen. (Education, I044, 917-927)

In addition, as the hierarchical nature of the health services changes radically, one Medical Consultant stated:

> *The power base is shifting and we are becoming more and more advocates, advisors, facilitators and less and less are we in a power relationship really … That is calling for different skills. It is calling for advisory skills…communications skills… It is calling for people to be better able to explain their judgements and their decisions. (Medical Consultant, I021, 1746 … 1757)*

A number of the participants referred to a study carried out in 2000 on behalf of the OHM (OHM, 2000) which listed the competencies that would be required by senior nurse managers (Education, I045, 687-699). That study provides a useful point of reference when considering the competencies and skills that will be needed in the present and future.

7.4 Future Skills Required

The third category identified under the theme 'Building Skills and Competencies in Nursing and Midwifery', was future skills required (SF). A total of seven codes were included under the category SF. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 7.3 Codes, Definitions, Frequencies – Future Skills Required

Code	Definition	Frequency
SKSFCO	Nurses and midwives will need communications skills in the future.	47
SKSFFS	Nurses and midwives will need greater understanding of and training in financial skills for health care professionals in the future.	48
SKSFID	The ability to work in an interdisciplinary environment will be an important dimension of the future skills required of nurses and midwives.	32
SKSFMG	Management skills will be very important for nurses and midwives in the future.	24
SKSFPM	People management skills will be very important for nurses and midwives in the future.	44
SKSFRE	Nurses and midwives will need more highly developed research skills in the future.	49
SKSFSP	Nurses and midwives will be more specialised in future health services.	13
	Total	257

A total of 257 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided.

This section of this chapter gives us an opportunity to take a closer look at some of the more specific skills that participants in the research chose to highlight as being of importance to the future role of nurses and midwives in the health services. The table provided above refers to 7 skills. In the member checking exercise (4.10.4.2) there was 100% agreement with the statements made about the need for these skills, with the exception of financial skills, for which there was 90% agreement.

Participants used the list of probes in the questions (7.1) as a spur to comment on the range of skills, or the skill-sets that nurses and midwives used. They also engaged in a ranking exercise. Most of them placed communication and people management skills at the top of the list. Quite a number of them spoke about

the complementarity of many of the skills and spoke more about the kind of person that was needed, well rounded, broadly educated, with a strong sense of professional identity and accountability.

One of the participants (*Education, I044, 1815…)* spoke about *'a fundamental skill … a human interaction skill'*. Included in this is the idea of respect for persons, colleagues, patients and clients. This *'fundamental skill'* provides a platform, a context on which to build skills like communication, working in teams, interdisciplinarity, people management, general management. This *'fundamental skill'* also provides the basis for an ability to speak out courageously on issues that are important. It provides the basis for the self-confidence that nurses and midwives need to intervene and make their voices heard in public debates and private discussions on how the services should be developed and delivered, and on issues of importance to staff and patients.

Many of the participants highlighted people management as a problem within nursing:

> *We have seen a lot of problems in relation to people management within nursing … management have to intervene a lot more than they should have to in people management areas within nursing. (Service, I047, 522…532)*

A number of participants commented that there continued to be a lot of bullying and destructive behaviour within the profession of nursing (*e.g. Policy, I007; Director NMPDU, I054; Service, I047; Education, I044*)[43]. In one situation, reference was made to a quality of life survey among health services staff in a

[43] Section 6.2 in chapter 6 contains reference to the treatment of the theme of bullying within nursing and midwifery by the Commission on Nursing. The points raised there are of relevance to this topic. Also of relevance are issues discussed in section 6.4 on leadership. In addition, chapter 3, sections 3.3.2 and 3.3.3 address issues on leadership and empowerment that are also of direct relevance to the points raised here.

wide geographic area *(Service, I047, 521-574).* One of the results of the survey showed that nursing emerged as the area where bullying was most prevalent. Most of the bullying was coming from within the profession, but also from patients and across the disciplines of medicine and administration. The main problem, according to the survey, appears to be how nurses feel they are being managed or disempowered within their own profession. Participants in the survey spoke about individual nurses and midwives feeling that they were being *'got at'* by their nurse managers, that the interpretation of rules was being used in a very unfair way to individuals at ward level. Participants in the survey identified problems such as these at ward level and at more senior levels within nursing and midwifery. Some also spoke about the problem of a Director of Nursing's span of control being too wide to enable him or her to detect problems such as these at lower levels within the system.

Part of the problem, according to a number of participants, is that we expect people to slot immediately into management roles without any adequate preparation, without serious thought being given to the 'people management' skills that are needed and the support managers need in dealing with this very complex area of management:

> *People management is the most difficult bit of management… it is the subtlety in how you manage people… and it is not fair to ask somebody to go out there day one, somebody who has never, and ask them to supervise maybe 10 or 20 of their colleagues without them having thought or without having had an opportunity to work through the skills that are involved in that. (Service, I048, 981…995)*

Bullying and treating colleagues badly stems from a lack of the *'fundamental skill'*, the human interaction skill, the sympathy skill, that is at the heart of communication, people management and many of the other skills referred to by participants. Related to this is the ability to handle stress, which is an essential skill in situations where we are dealing with *'either a vulnerable public or a*

demanding public', which is what nurses and midwives usually have to deal with. One participant referred also to the *'gentleness required with our own staff and with patients, particularly in difficult situations'*. This is particularly important in determining the borderline between being 'assertive' and being 'aggressive'. Knowing the difference between both of these and being aware of how one comes across is a skill, and a level of awareness that is frequently lacking in nursing and midwifery (*Education, I044, 1815…)*.

> *People management… I don't think we do half enough in terms of training our future managers of any kind in the health services. It is all hit and miss and grabbing the odd course here and relying on people's own skills, but compared to the NHS we are still not at the races. (Service, I059, 441…449)*

The message therefore is that we are dealing with a complex set of interacting human competencies rather than a list of self-contained, isolated, unilateral skills. What is required is an approach to developing the whole person. Much of this can be done through education and there is a need to take a hard look at the approach we have to education, both pre-registration and post graduate, in the development of the people who work as nurses and midwives.

One of the participants chose to emphasise the *'ability to destroy'* people that exists within the profession, and the lack of awareness that people can have of the fact that they are doing it. People who do this and are not aware of the fact that they do it need help. Something needs to be done to *'dissipate the ability to destroy people'*. One of the participants provided more evidence of the *destructive force* within nursing and midwifery in situations where individual nurses and midwives experienced considerable resistance from senior managers when they sought to improve themselves through education and training. People being blocked from becoming specialists in their areas, introduction of advanced nurse and midwife practitioners, and being forced to give up their jobs to take on further education. This was described as *'some pockets of unbelievable resistance and ignorance and lack of willingness to*

support staff in the system, particularly in the acute hospital sector, I would say they are not desperately very visible.' (Education, I044, 1255…1259). The *destructive force* therefore is not always *visible* – it is latent but very potent. Another participant described this in even more graphic terms:

> *Nurses are not always kind to one another as people managers… they crucify one another.* (Policy, I007, 657-659)

It raises the question about what can be done to protect nursing and individual nurses and midwives from being destroyed by those who have this power and *ability to destroy* within nursing. If nursing and midwifery can dissipate the most destructive elements within the profession:

> *Then I would say we are well on the way. I think we certainly have the capacity. I think there is awareness, but I think there is a fear. I think the fear can be somehow dissipated partially by … getting more information into the system … not being afraid to say you do not have [the information]… (Education, I044, 2088…2092).*

This participant went on to say that nurses and midwives need to be prepared to challenge each other at every level in a positive way, with a constructive challenge. This means asking a lot more questions, doing a lot more thinking into staff support in various ways. It requires support for staff in ways that encourages a lot of talk, sharing the uncertainty and helping them to live with the uncertainty.

One of the service managers spoke about the difficulty in the recruitment of Directors of nursing posed by the narrow experience base of many of the candidates and the fact that there are not enough people coming through the system at the level of management competence that is required (*Service, I022, 485-492).* Another participant commented that arriving at the interview with an MBA is valuable but it is not enough to prepare someone to manage up to 1,000

staff in a large acute tertiary referral hospital (*Service, I043, 834-848).* The narrowness of their management skill and experience base present challenges for the training and education of senior managers within nursing and midwifery[44]. This is particularly exacerbated in what one service manager participant referred to as *'the paralysed environment'* (*Service, I043, 767-773*) that has emerged within some large acute hospitals because of bitter industrial relations disputes. It is impossible to expect someone to land into a situation like that and expect them to manage without adequate preparation and training. This training for senior managers was referred to earlier when we spoke about leadership within nursing and midwifery (6.5). It emphasises the need for specific, multidisciplinary training for senior managers within nursing and midwifery that equips them to work within the complexity of the environment of the health services.

Participants also spoke about areas of management that they considered to be included in the list of competencies referred to in the probes but which needed to be articulated:

> *Empowering patients, problem solving, project management focus, engagement with partnership, reflection, quality assurance audit, evidence based, protocols and guidelines, and what I call real accountable management like appraisal and dealing with IR and giving and taking feedback and leadership… So I suppose all of those can be elements of these. (Service, I036, 657…669)*

With regard to specialisation, a discussion took place in one of the Focus Groups for Band 1 and 2 directors of nursing and midwifery (*Directors of N&M, FG01*), on the use of increasing numbers of CNSs and ANPs. One of the participants expressed reservations about their use, referring to the fact that

[44] This contrasts with what many participants referred to as the broad based competence of nurses and midwives in clinical settings and their overall understanding of hospitals and the health system. See discussion on this in chapter 6.

every Medical Consultant in the hospital is looking for CNSs. The same participant also made reference to what was described as the danger of becoming dependent on one individual – as an ANP for example, builds up a clinical practice within the hospital; a problem arises when there is no locum to replace them for periods of extended leave such as maternity leave. This was not a view that was supported by the other members of the group. It does provide evidence, however, that not all senior nurse managers of acute hospitals are of the same mind in relation to the increased specialisation of nurses and midwives, and the role they can play within acute and community hospital settings. Within the same group, other participants spoke in glowing terms about the roles they can play and about the need to ensure that they also had the opportunity to follow up their patients into the community.

With regard to research, participants commented on the importance of building within nursing a research competence to underpin the increased emphasis on evidence based practice. Participants spoke about the need to educate nurses and midwives in research skills and to examine opportunities for increased involvement of nurses and midwives in dedicated research activities. One participant (Service, I059, 429-439) suggested that consideration should be given to the development of opportunities within nursing and midwifery for a small number of people whose main contribution would be in research. This should mirror the *clinician scientist* posts that exist in medicine, where a clinician carries a case load within the clinical area but spends most of their time involved in research.

Finally, many of the participants wished to emphasise the positives about nursing and midwifery in Ireland. Those with a nursing and midwifery background were particularly keen to emphasise what they saw as an exciting period in the development of the profession and an exciting time to be involved. Great emphasis was placed on the need for concerted action from within the profession itself in order to get things done. The point was made by many that people at the most senior level within the profession need to engage and provide leadership:

We have a lot of work to do and we have a lot of hard thinking to do and if we do not do it, we will miss the boat and that is irresponsible for anyone in our kinds of positions in terms of the future of the profession in the country. (Education, I044, 2340-2346)

7.5 Skill Mix

The fourth category identified under the theme 'Building Skills and Competencies in Nursing and Midwifery', was skill mix (SM). A total of five codes were included under the category SM. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 7.4 Codes, Definitions, Frequencies – Skill Mix

Code	Definition	Frequency
SKSMBS	As the scope of nursing and midwifery practice expands, nurses and midwives will require the skill to span the boundaries between professions.	72
SKSMCJ	There is a need to a more structured approach to skill mix within the clinical setting and to ensure that professionals are freed up to concentrate on their core job rather than caught up in a lot of administrative duties.	34
SKSMHA	There will be a need to train and utilise to the full health care assistants as part of the skill mix in the nursing and midwifery settings.	20
SKSMNR	It is important to monitor the overall ratio of nurses and midwives to patients in Ireland.	11
SKSMRE	There will continue to be significant retention and recruitment issues in nursing and midwifery in Ireland and the resultant need to rely on nurses from other countries (e.g. India, Philippines …)	18
	Total	155

A total of 155 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided.

Boundary spanning was one of the probes used in the questions (7.1), but it attracted a lot of comments from the participants in this research and as a result 72 segments emerged from the coding exercise, accounting for almost half the total number of segments in this category. The other popular topic under this category, and one that was not the subject of a probe (7.1) was the one that referred to freeing up nurses and midwives from administrative duties and other non-clinical duties, in order to enable them to concentrate on their core job (32). Participants also raised of their own accord, without the need for a probe, the issue of recruitment and retention within the profession (18), including the question of dependence on foreign nurses within the services. Related to this was the question of monitoring and maintaining the ratio of nurses and midwives to patients, which was also raised by participants without the use of a probe (11). Finally, the issue of the increasing importance of healthcare assistants within the profession was also raised by the participants unprompted (20).

A number of participants raised the question about the ratio of nurses in Ireland, stating that they believed that Ireland had the highest ratio in the OECD. This point is frequently made as an argument against recruiting more nurses or when discussions are held regarding staffing numbers[45].

When speaking about boundary spanning as a factor in skill mix, participants were almost universally in favour of the concept, with perhaps two individual participants thinking that it was not a good thing. Participants spoke about nurses and midwives coming back from having worked, for example, in the United States, and experiencing frustration at not being able to do things they took for granted over there (*Service, I001, 268-274*). They also spoke about it in the context of nurse led services within the community or in smaller hospitals where, for example, there is a low requirement for X-rays and it makes sense therefore for nurses to be trained and empowered to do them when necessary.

[45] See discussion on this in the section dealing with employment in the health services in Ireland in chapter 1 (1.2.2)

The example of the emergency medical technicians was quoted by a number of participants, whose role has expanded in recent years to areas of prescribing, giving injections and other elements of emergency care.

One of the Directors of the NMPDUs spoke about their intention to conduct an audit of the expansion of practice in their area to take stock of the skills that nurses and midwives have developed as part of their expanded practice and to assess whether or not they are still competent in those areas. (Director NMPDU, I009, 566-575). One of the participants expressed the move in this direction as follows:

> *There is a reach upwards and there is a letting go of tasks and functions… and I think that is something that has high value in a quality focused health service. (Policy, I014, 687…691)*

Many practical examples of this emerged in the contributions of the participants. One example from midwifery describes how duties that were once the responsibility of the doctor are now being performed by the midwife:

> *[In] other aspects of intrapartum care historically … midwives have been the main prime care givers but they have often expressed an interest about the possibility of doing ventouse deliveries or possibly foetal blood sampling in labour… again duties that in the past have been duties of the doctor. (Medical Consultant, I024, 191-201)*

The same participant went on to comment that this was more a case of midwives seeking and developing more autonomy and keen to take on these roles rather than a case of doctors looking to hand them over. This participant expressed the view that this was something that was likely to increase in the future, a view that was echoed by many other participants.

The idea of expansion of practice (An Bord Altranais, 2000a) and of boundary spanning was also frequently mentioned in the context of the EWTD (6.3) which was expected to have an impact on the availability of medical manpower and create pressure for nurses and midwives to take on roles that traditionally were done by doctors. Many participants felt that this was not a good basis for role development. There is a need for a more strategic assessment of what the role of the nurse and midwife should be within the services rather than looking for them to fill gaps left by others (Service, I047, 179…185).

Some participants, however, did talk about some of the difficulties within the services in relation to role expansion. In a move to modernise the service by expanding the role of nurses and midwives, some resistance was being experienced from medical unions, and some doctors who are *'precious…protective…and defensive'* about their territory, and some nurses *'holding onto their territory as well with the care assistants aspiring to move into some of their patch'* (Service, I067, 269…288). The participant referred to it as *'a lot of protection of old boundaries and still a lot of the demarcation mentality around'*.

As the profession progresses to more community based nurse and midwife led services, this will become more prominent and more important, and it has an important message to communicate to the patients and clients of the services:

> *Boundary spanning … it has got to be … across these boundaries... We have got to get to a stage where that stroke patient … and that family of that stroke patient should find that among his multidisciplinary team there is one person who no matter what the problem is will take responsibility. (Service, I075, 622…631)*

Many participants referred to the need for nursing and midwifery to spend time reflecting on what its core functions would be. As the role expands and as health care assistants take on more responsibilities and clerical and administrative staff take on functions that nurses and midwives previously did, it is necessary

for the profession to reflect on what its core is (*Service, I012, 152-158*)[46]. This was articulated by one participant in relation to midwifery, in a setting where there were already five or six clinical midwife specialists in areas such as cancer, urodynamics, diabetes, as follows:

> *Whether midwives should go totally specialised in that they only work on the labour ward and don't work on the post natal and ante natal or whether they fulfil all the duties of the midwives and rotate between the wards, that is a question that has never been decided in the profession as to what is the best way to go. (Medical Consultant, I024, 340-349)*

Another medical consultant participant in this research spoke about the importance of *'the totality of care'* which is at the heart of nursing, including relationship nursing involving spending time to talk to the patients about their home circumstances, their family, their grandchildren, and the danger that this will disappear because they are so busy doing so many other things in the clinical area: *'the human dimension of health care delivery and service to patients must encapsulate that totality and we are becoming very clinical and that would worry me a little bit* (*Medical Consultant, I060, 299…311*). This is a point of view that was articulated by a number of participants.

Quite a number of participants also chose to comment on the question of recruitment and retention within nursing and midwifery[47]. Most of those who commented made reference to our increased dependency on foreign nurses as part of the workforce and wondered about the sustainability of this as a strategy. Others spoke about the difficulties of retaining nurses and midwives in the clinical area due to inflexible work practices and an increase in the medical / legal climate (especially in obstetrics). A number of participants concluded that

[46] See discussion on the essence of nursing in chapter 2 (2.7) and information on the use of healthcare assistants in chapter 3 (3.2)

[47] See discussion on recruitment and retention in nursing and midwifery in chapter 3 (3.2)

there is a need for nurse and midwife leaders to put work into making it attractive for nurses and midwives to stay in nursing and midwifery, especially the young educated ones that need to become the leaders of the future.

This would include, for example, making it easy for people to have access to development opportunities and proactively to support people with more flexible work practices. One participant said that she was *'absolutely horrified'* when she discovered that some Bachelor of Nursing Studies (BNS) students had to give up their jobs at the height of a retention crisis in order to do the BNS:

> *There are still some pockets of unbelievable resistance and ignorance and lack of willingness to support staff in the system. (Education, I044, 1250…1258)*

Another participant spoke about the *'unbelievable archaic structures in place in the mental health services, and they are pervasive'*, referring to practices such as central rostering, holidays by seniority and other outdated HR and management practices that have been done away with, particularly in the voluntary sector of the mental health services, many years ago. None of these approaches are conducive towards retaining and encouraging staff within the profession. A number of approaches to the development of strategies for recruitment and retention in Ireland and abroad have already been discussed in chapter 3 (3.7).

7.6 Pre-Registration Education

The fifth category that emerged under the theme 'Building Skills and Competencies in Nursing and Midwifery' was pre-registration education (PR). One code was included under the category PR. The following table provides a definition of the code used and an indication of the frequency of the occurrence of the code within the texts.

Table 7.5 Codes, Definitions, Frequencies – Pre-Registration Education

Code	Definition	Frequency
EDPREV	There is a need to evaluate the effectiveness of the pre-registration education for nurses and midwives.	84
	Total	84

A total of 84 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided[48].

Participants in the research were anxious to make comments about the move to a degree programme for nurse education. One of the participants referred to it as *'the biggest single change in nursing in the last 50 years'* (Service, I018, 355-358). As a result, this code was the fourth most frequently used during the coding exercise (84).

The vast majority of participants saw the move to a degree based educational system for pre-registration nursing and midwifery as very positive. In general, they saw it as giving nursing an equal footing with other professions and felt that it would enhance nurses' knowledge and understanding and make them more confident in asking questions and demanding standards within the system. They also commented that nurses emerging from a degree programme would have a different view of themselves than in the past and would have higher expectations about their role, its positioning within the system and their own professional identity. All of this was seen as positive.

On the negative side, participants spoke about the dangers of removing nurses more and more from the bedside. Medical consultant participants in particular expressed concern at some aspects of these developments.

[48] See also discussion on pre-registration education in chapter 2 (2.4.1)

One Medical consultant participant spoke about the fact that in the education of doctors there has been a trend towards more integration into the clinical area, with more of an emphasis on skills rather than academic knowledge, and that this was mirroring what nursing education and training used to be:

> *Nursing has gone hugely in a single generation in the opposite direction and I don't think, that's ultimately not going to work out well. (Medical Consultant, I011, 1085-1090)*

The participant spoke about the *'unpicking of academic orientation in medical training'* and an increased emphasis on *'more integrated into the clinical area, more skills focus, like nursing was…'* Another participant, also a medical consultant, spoke about the danger of producing a theoretical nurse and not a practical nurse. The participant questioned whether *'the new order had gone too academic and not retained the important part because ultimately nursing is very practical and it must be* practical' (Medical Consultant, I060, 717…727).

This is not a view that was supported by all medical consultants who participated in this research. One medical consultant in particular saw it as a positive development that should lead to more nurse-led developments in the role of nursing:

> *There is still a hankering for the good old days and when you actually go back and look at them they were not that good. The concern is that some of the sort of caring ethos could be lost in the academic model but I think that that is a reasonable concern but I do not see any evidence to justify it. (Medical Consultant, I035, 183-193)*

The participant went on to speak about nurse specialists in areas like diabetes and cystic fibrosis that have made a huge impact on the quality of care that patients get and on the continuity of care they get. The participant felt that nursing was seriously under-utilised, an important consideration when one

thinks about the *Hanley Report* (DoHC, 2003c). According to this participant, the move of nursing towards more university based education at pre and post-registration should contribute to the development of a more sophisticated range of nurse led role developments.

Participants also made some comments about the shape of the degree programme itself. Some participants felt that there should be a common point of entry to all branches of the profession (*Service, I048, 1133-1141)*. This would reflect what happens in the UK and most other countries with a degree programme for nurse education. The common point of entry would entail all nurse and midwife students sharing a common first year or 18 months at University and then choosing which branch they would take. The advantages of such a system would be the creation of greater interdisciplinary solidarity within the professions and the development of common standards across all the branches of the profession. As it stands, Ireland is the only country that has five separate degree programmes (General Nursing, Psychiatry, Midwifery, Children's Nursing, Intellectual Disability). Other participants however, emphasised the advantages of developing individual degree programmes, with different points of entry, in order to ensure that the specific demands of each branch of the profession received sufficient attention *(Trade Union, I068, 628-637)*. There was general agreement that the *"five points of entry is now here to stay" (Trade Union, I073, 568-571)*.

Some participants also commented about the clinical year and expressed the desire that it should be replaced with an internship similar to that of medical students. A number of participants from the policy and education categories commented that by 2010 the Bologna Declaration (European Ministers of Education, 1999) would take effect and that would involve a change to a three year degree programme, followed by a year of internship (Appendix 20). Many of the participants would agree with the comment from one service manager that *"there could be more of an emphasis on clinical placements"* (*Service, I064, 315-318*). In general, it was felt that the organisation of the clinical placement experience was something that would need to be re-examined

It is clear therefore that changes will happen in the coming years in the degree programme for nurses and midwives. A number of the participants in this research suggested that it was time now to conduct an evaluation of the degree programme experience to date, to review what changes needed to be made and what lessons had been learned. The implementation of the *Bologna Process* and *European Higher Education Area* (Appendix 20) will have significant implications for clinical placements and other elements of the current four year degree programme. Participants who commented on this suggested therefore that it is an opportune time now to conduct an evaluation of the whole programme. Such a review would present the opportunity to examine again options such as single point of entry to nursing and midwifery, shared common basic education for nurse and midwife students, and the advisability or otherwise of sharing some education with other university based students in areas such as science, medicine and other health disciplines.

Many participants in this research would be of the view that it is probably time to conduct a review of the Degree Programme for nursing and midwifery. Some concern has been voiced however about the advisability of conducting a full scale value for money review just one year after the first cohort of degree students have graduated (O'Brien, 2007). There is also evidence from research conducted in the United States that education in nursing and midwifery has a positive impact on patient outcomes (Aiken et al, 2003).

Participants in this research were of the view that the changes in education for nurses and midwives would have a lasting and fundamental impact on the quality of nursing and midwifery. It was generally recognised that these changes were among the most important legacies of the Commission on Nursing:

> *The impact of the commission on nursing; I think that it has been huge and I don't think we will really be able to see that impact for quite a while … the commission on nursing has … lifted nursing out of a system of training which belonged at the beginning of the last century … and locating nursing*

within the higher education sector… I think people will look back and it will be like the nurses that were first being registered, I think that is the equivalent of it, it will be of that impact. (Education, I072, 678…729)

7.7 Post-Registration Education

The sixth category that emerged under the theme 'Building Skills and Competencies in Nursing and Midwifery' was post-registration education (PD). One code was included under the category PD. The following table provides a definition of the code used and an indication of the frequency of the occurrence of the code within the texts.

Table 7.6 Codes, Definitions, Frequencies – Post-Registration Education

Code	Definition	Frequency
EDPDEV	There is a need to evaluate the effectiveness of the post-registration education for nurses and midwives.	91
	Total	91

A total of 91 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided[49].

The topic of post-registration education is closely linked to that of CPD. A separate code exists in this research exercise on the topic of CPD (7.8). Post-registration is one way in which the broader question of CPD is addressed within the service. It provides the vehicle for the provision of formal educational programmes at Post Graduate Higher Diploma level, at Masters level and relates to the development of educational interventions that match the needs of the service. CPD on the other hand refers to the broader challenge that every professional faces of engaging in a lifelong process of continual refreshment of

[49] See also discussion on post registration education in chapter 2 (2.4.2)

their knowledge and skills. CPD is an integral part of what it means to be a professional. Post-registration education is an important element of that, a vehicle through which it can be attained. We will return in more detail to the question of CPD in the next section of this chapter (7.8). Here we are dealing with the provision of educational opportunities at post graduate level and the broad question of post-registration education opportunities for nurses and midwives.

Participants spoke about the need to ensure that the provision of post-registration education matched the needs of the service and of practice. In general, there was agreement that much progress had already been made in this: *"right around the country we have tried to create programmes, both the service people and the university or educational people, to match the needs. I do think we have done a good job" (Education, I045, 836-841)*.

A participant from the Institutes of Technology spoke about the importance of developing partnership relationship between the major provider of educational services, towards the development of regionalised centres of expertise, rather than individual colleges looking to provide everything in each individual college. This gave rise to a comment from the same participant about the differences between Institutes of Technology and Universities, which was described as *Institutes of Technology are regionally based and focus on the needs of the region (Education, I077)*.

Participants spoke about the need to differentiate between needs analysis at local level and at national level. One participant spoke about an initiative in their area where *"proper needs analysis tools are being developed regionally here and are being given to all local managers" (Director NMPDU, I041, 773-776)*. The participant spoke about the importance of doing proper needs analysis at unit level and developing local strategies that complemented national strategies.

The discipline of conducting needs analysis on a regular basis, updating it in line with changing and evolving agendas was also mentioned by a number of participants. One service manager commented: *"matching to needs is something that would have to be kept very closely under review … on an ongoing basis" (Service, I046, 788-794).* One participant spoke about the need for a proactive approach rather than a reactive approach. A reactive approach seeks to *"address immediate situations"* whereas what is required is a *"a more proactive approach, long term… what has been absent is the visionary 10 or 20 year plan of where nurses will be, what will they be doing, who will their client population be?" (Education, I069, 239-247)*.

The ongoing assessment of relevance to need was described by one participant as:

> *We need to remember that the agenda is evolving and therefore we need to be able to look honestly at our provision and drop parts of it when it is not appropriate and work in areas where it becomes necessary. (Education, I044, 2302-2309)*

One of the emerging areas of need identified by the previous participant, and one that is not adequately addressed at present is *"the shift in the community agenda" (Education, I044, 2315)*. This is a topic that was picked up by a number of participants. There was a feeling that post-registration educational opportunities need to be tailored to meet the emerging needs of professionals working in the community. As we have seen elsewhere in this research (chapters 5 and 6), there is an unstoppable shift in emphasis from acute settings to a population health model based on health education and promotion at community level and at providing services to patients in their own settings in the community. Post-registration educational opportunities need to be developed that reflect this shift. One participant expressed it as follows:

> *Population health … I think we need to reassess what we need to do within nurse education … undergraduate and*

> *post graduate level … we need to examine where we are going with education now that we know what the new developments are going to be. (Director NMPDU, I050, 856-864)*

Another issue raised by a number of participants was the question of access, accessibility and flexibility. Participants spoke about the need for post graduate education programmes to be *"more accessible and flexible to nursing and midwifery students"*. The participant expressed this desire for flexibility in terms of *"greater variety programmes … flexibility in entry requirements … in modular programmes"* to suit the needs of the services and of nurses and midwives in a wide variety of service settings and personal circumstances *(Director NMPDU, I041, 778-794)*.

Participants also spoke about the need for programmes to demonstrate relevance to practice. In this context a number of participants referred to the concept of *"learning contracts"* and the importance of determining relevance to practice in the workplace in advance of study being undertaken and being approved. This kind of prior analysis of relevance can then be converted into a learning contract, under which the student contracts to achieve a level of skill and knowledge that is directly relevant to the needs of the unit at a local level. Allied to this is the concept of education provision having an impact on service. The previous participant commented in this regard: *"one thing we are attempting to address … now is having an impact on service because sometimes you can run an awful lot of education and you are wondering is it really impacting on the service" (Director NMPDU, I041, 718-724)*. Another participant expressed concern about *"how relevant it is to corporate needs"* stating that frequently educational interventions did not match those needs, quoting as an example *"training doctors to be more specialists when what we want is more generalists … and we don't train them to work in teams" (Service, I036, 747-758)*. Closely linked to the concept of learning contracts is the idea of *"personal development planning" (Service, I034, 462)*. A number of participants spoke about the importance of this from a personal, a professional

and an organisation point of view. This is something that we will return to when we speak about continuing professional development (7.8).

Relevance to corporate and service needs and effectiveness was also raised in the context of combining knowledge base with skills. One participant spoke about the need to ensure that education is not focused solely on the acquisition of knowledge but it should also include the acquisition of skills that are relevant *(Service, I036, 896-913)*. One participant called this *"purposeful investment education and training … so that the people who come back with those skills are immediately put into a position where they can use them" (Trade Union, I068, 886-891)*.

Talk of investment in education raises the question of budgets for training. One service manager spoke about the importance of protecting these budgets: *"[education] is as critical as trying to provide service needs but it has tended in the past to be one of the areas that suffers once there are cutbacks"* the participant commented: *"managers and nurse managers … have to try and protect these resources" (Service, I047, 738-743).*

A number of participants made reference to a recent HSE initiative to examine Post-registration Education *(e.g. Service, I076, 1165-1198)*[50]. The review concluded with a series of recommendations in the areas of practice, education, policy and research (Appendix 13).

7.8 Continuing Professional Development

The seventh category identified under the theme 'Building Skills and Competencies in Nursing and Midwifery', was continuing professional development (CP). Two codes were included under the category CP. The following table provides a definition of the code used and an indication of the frequency of the occurrence of the code within the texts.

[50] See discussion on PRERG in chapter 2 (2.4.2)

Table 7.7 Codes, Definitions, Frequencies – Continuing Professional Development

Code	Definition	Frequency
EDCPEV	There is a need to evaluate the effectiveness or otherwise of CPD as a way of addressing skills deficiencies in nurses and midwives.	65
EDCPJA	There is a need to use more the opportunities to make joint clinical / educational appointments.	5
	Total	70

A total of 70 segments were singled out from the interviews during the coding exercise, the vast majority of which (65) related to the need to evaluate the effectiveness of the provision of continuing professional development for nurses and midwives. Some samples of the comments made are included in the texts provided[51].

Participants universally endorsed the importance and value of continuing professional development. Many participants expressed the view that it should be a requirement of professionals to refresh their skills and knowledge periodically and this is best done through a modular system of continuing professional development.

Among the practical difficulties associated with participation in CPD, participants referred to access at a local level and staff release. The combination of difficulties in obtaining release for staff to attend courses and the need for staff to travel distances to attend militated against regular attendance by staff members who were very busy. Some participants commented that the failure to address these issues resulted in the wrong people attending CPD: *"people that are in the middle of their careers that are contributing the most are the ones that are participating the least" (Policy, I004, 496-501)*. People who are in the middle of their career and working in very busy

[51] See also discussion on Professional Development for Nursing and Midwifery in chapter 2 (2.5).

units are the ones who would benefit most from participation in meaningful CPD courses.

A number of participants also referred to the fact that provision of CPD opportunities needs to reflect the circumstances of the people who need it:

> *Predominantly female, higher numbers of flexible working, higher numbers of job sharing, people not available for full time education as they are in full time employment … we have to have a more flexible friendly approach to how we deliver educational packages. (Policy, I007, 989-998)*

Participants also spoke about *"getting staff released … we are having huge difficulties … getting staff released to undertake training"* and as a result this participant called for *"much more localised based training … within the sites, e-learning … and probably distance learning programmes for people … to avail of education without necessarily impacting negatively on the service in terms of staff release" (Director of NMPDU, I009, 989-998)*.

Some participants also spoke about the need to make it obligatory for professionals to demonstrate that they are undertaking professional development at regular intervals. A small number called for the introduction of compulsory CPD as a condition of re-registration, but most who commented on this recognised the practical and resource difficulties associated with introducing this and called instead for a voluntary system, driven by guidelines based on the principle that:

> *If you are going to be competent, you are going to have to provide evidence that in fact you are attending courses that are appropriate. (Service, I012, 489-493)*

This was seen as an important part of building a culture of personal professional accountability:

> *I see it as part of a cycle that once people are clear of their own accountability and what they need to keep up to speed with (Director NMPDU, I026, 814-818)*

The participant went on to link this with the role that clinical audit could fulfil in this regard: *"if you have clinical audit or continuous quality initiatives, that will inform teams, including nurses, what skills people need, but that is an area that I see as being something to be developed" (Director, NMPDU, 818-823)*. There is a link therefore between professional accountability, quality and clinical audit, and an important potential role for clinical audit at a team level that considers the skill mix within the overall team.

Participants also commented on the lack of proper evaluation of those programmes that are on offer and the lack of an overall analysis of the CPD needs of the profession that could form the basis for the development of a coordinated strategy. This lack of evaluation makes it very difficult to assess whether those courses that are on offer are offering value for money or having an impact on the skill levels of those who attend. Participants spoke about the need to make sure that the provision of CPD was in line with what was needed:

> *There has to be a regular sampling of programmes that the taxpayer is paying for to see if that is what is required out there. (Service, I006, 1010-1013)*

Some participants linked the development of a coordinated strategy for CPD to the wider question of professional development, performance appraisal and review. It should be an integral part of the HR systems that exist within the profession that people are given proper feedback on their performance through an appraisal system and an opportunity to discuss a development programme that meets their own professional needs and the needs of the service within which they are working. Such a system would also contribute towards the development of more practice relevant CPD opportunities as the nature of the needs of the professionals and of the service would become clearer and feed

into the development of educational interventions (*Director NMPDU, I041, 727-738; Education, I055, 633-647)*.

Some participants referred to the publication by the National Council of guidelines portfolio development for nurses and midwives (National Council, 2003b and 2006d) *(Regulation, I030, 1200-1203)*. The use of the portfolio increases awareness within the profession of needs and opportunities and provides professional nurses and midwives with a practical mechanism for planning and tracking their development needs. It is also useful in assessing the levels of competence of professionals and tracking the extent to which skill sets are being renewed and refreshed. Portfolio development is also seen as a useful tool in the wider education and development of the individual as it provides a stimulus to examine wider educational opportunities and needs *(Director NMPDU, I050, 822-837)*. Portfolio development and management is also seen as a practical way of integrating professional development into the clinical area and take account of the development that is happening through experience *(Medical Consultant, I066, 505-517)*.

Participants also commented on the opportunities presented by CPD interventions for interdisciplinary and multidisciplinary educational opportunities.

> *Multidisciplinary, now that is where continuing professional development comes in and that should be more multidisciplinary … we have to talk to one another … everyone being in their own silos … it is still there … we have not done a great deal to break down those walls. (Trade Union, I073, 665-674).*

The National Council provides continuing professional development support to nurses and midwives in the form of career progression advice, open days, site visits, assistance with job descriptions, management advice and support. This includes regular regional meetings organised in collaboration with the NMPDUs for directors of nursing and other senior manager and stakeholders for the

purposes of keeping them informed about development opportunities and providing advice on professional development issues.

A small number of participants chose to comment unprompted on the value of joint appointments. Despite the small number of comments, because of the fact that the comments were unprompted, it seems worthwhile just briefly drawing attention to the points that were made.

The directors of CNEs who took part in the focus groups for this research commented on the disappointment they felt about the lack of integration between the clinical and third level setting:

> *In some instance a lot of people coordinating the under-graduate programmes at the Universities are not people who ever had any experience in the area. In fact quite the opposite… and* [with regard to] *the lack of integration between the University and the clinical setting … we were told there would be shared learning and lecture-practitioners … the University people rarely visit* [the clinical setting] *and if they do… it is a social visit and that is poor integration of theory and practice (Directors of CNEs, FG04).*

Medical consultant participants in particular commented on what they saw as the consolidation of a divide between the clinical setting and the academic setting by the lack of involvement of senior lecturers and professors of nursing in clinical setting. They commented that, despite the many criticisms that are made of 'the medical model', this is one aspect that the profession of medicine valued very highly. With the exception of basic education at the very beginning of their careers, medical students are taught by practising clinicians. The profession has resisted attempts to shift towards the academic paradigm of pure research and pure teaching, because of what they perceive as the immense value of maintaining those close links between academia, clinical practice and research *(Medical Consultant, I011, 405-419)*. The participant

added that there was *"no reason why there should not be lecturers, senior lecturers and professors of nursing working on the wards"*.[52]

One of the participants also referred to the potential that existed for the creation of a nursing equivalent of the *'clinician scientist' (Service, I059, 429-438)*, whereby an individual works within the clinical area, with a clinical caseload but whose main focus is the development of research.

7.9 Common Education

The eighth category identified under the theme 'Building Skills and Competencies in Nursing and Midwifery', was common education (CD). A total of seven codes were included under the category CD. The following table provides a definition of the codes used and an indication of the frequency of the occurrence of the code within the texts.

Table 7.8 Codes, Definitions, Frequencies – Common Education

Code	Definition	Frequency
EDCDAD	There are advantages associated with the development of common education opportunities for clinical professionals from different disciplines.	121
EDCDDI	There are disadvantages associated with the development of common educational opportunities for clinical professionals from different disciplines	4
EDCDCO	Common training in communication skills should be included as part of a common education curriculum.	34
EDCDFS	Training in financial skills should be included as part of a common education curriculum.	5
EDCDHE	A general introduction to health economics should be included as part of a common education curriculum.	2
EDCDMG	Training in management and administration systems should be included as part of a common education curriculum.	20

[52] See discussion on Joint Appointments in chapter 2 (2.6)

EDCDTW	A common education curriculum should include training in team working skills.	22
	Total	208

A total of 208 segments were singled out from the interviews during the coding exercise. Some samples of the comments made are included in the texts provided.

The vast majority of the segments for consideration in this section (121 – 60%) of the chapter refer to what participants saw as the advantages of developing common education opportunities for clinical professionals from different disciplines. This code was the third most frequently used code throughout all of this research. Very few participants (4) saw any disadvantages.

Some of the participants spoke about the value of *"common basic education for clinical professionals" (Policy, I005, 748-749)*. Another participant commented:

> *When we educate all disciplines together we will break down these silos … and that each see how the other profession fits in. (Director NMPDU, I041, 836-840)*

Participants felt that in addition to developing shared educational opportunities in some areas of the clinical curriculum, students should also be offered common courses in areas such as communications, team working and management *(Policy, I005,768-772; Service, I006, 642-660)*. As one participant put it:

> *If we are going to be working as a team, then we should be training as a team. (Medical Consultant, I035, 421-423)*

The advantages of such a system included the creation of opportunities for clinical professionals to understand each other better and the contribution that their discipline made to the health services. It would create the opportunity for improved communication between the disciplines, building greater mutual

respect and fostering a spirit of teamwork as a basis for enhanced multidisciplinary cooperation in the clinical setting. The directors of the CNEs who took part in the focus groups for this research commented:

> *Common education will help. You see very diverse professionals there… and if they can actually manage to get together, then there certainly is hope for the future with regards to team-working (Directors of CNEs, FG04)*

Many of the participants suggested that this approach would introduce a radical transformation of the culture of the professions. In nursing and midwifery, one of the participants described the hierarchy of the branches as *'general nursing is number 1, psychiatry falls in at number 2 and then there is midwifery and the rest…'* (Service, I015, 711…717). The same is true of the relations between the professions, where a definite hierarchy exists. Learning and working together in college would help to eradicate this mentality and generate a greater respect for the respective roles of each profession and the branches within the professions.

Some examples exist within the educational system of moves in this direction. Participants (*Director NMPDU, I027; Education, I045*) spoke about a pilot project that involved the development of a Higher Diploma in Neonatal Intensive Care, using funding provided by the National Council. The course is multidisciplinary in nature and is being delivered to mixed groups of nurses, midwives and doctors.

The development of common education opportunities is likely to lead to an increase in the modular approach to course design *(Service, I028, 883-892)*, with an increase in the amount of interchange that would be possible between disciplines and between colleges *(Service, I029, 832-844)*. This is in line with the spirit of the EHEA referred to earlier, where interchange between colleges

and courses increases opportunities for students to build their competence and education around targeted needs and their own strengths[53].

7.10 Conclusion

Two aims were identified at the outset for this research. The first was: *"To identify the future role for nursing and midwifery within the Irish Health Services as perceived by key stakeholders within the services"* (3.2). In the conclusion to chapter 6 (6.8) a description was given of the key elements of the future role of nursing and midwifery in Ireland as perceived by the stakeholders who took part in this research. The second aim was: "*To identify the professional development implications for this role"* (3.2).

It is now possible to provide a description of the key professional development implications for this role as perceived by the stakeholders who took part in this research. These can be summarised as follows:

1. A single point of entry to the profession of nursing and midwifery should be provided, based on a common initial year in which the core elements of nursing and midwifery practice are emphasised. Subsequent division into specialised areas of practice should also include as much as possible elements of integrated, interdisciplinary education. This is an important element in developing and promoting a strong professional identity within the profession. This recommendation also anticipates the implications of the Bologna agreement (appendix 11).

2. A comprehensive and rich career pathway for nurses and midwives in clinical, management, education, research and professional development should exist, supported by the provision of a comprehensive range of educational, training and development opportunities at pre-registration and post-registration levels.

[53] See discussion on interdisciplinary education in chapter 2 (2.4.1)

3. Joint appointments, in line with agreed frameworks and protocols, should be encouraged and available across all the career pathways.

4. A detailed description of the competencies required for each career pathway in nursing and midwifery should be provided.

5. The role of nurses and midwives should be developed in accordance with agreed frameworks for the expansion of practice, practice development, accreditation of education and training provision, and approval of posts, registration requirements, and professional development provisions.

6. The development of the role of nurses and midwives, including the determination of the numbers that will be required within each pathway and at each level of practice / management grade, should be determined based on a strategic assessment of service needs.

7. The direct entry degree programmes should include some elements of common basic education, through the development of modules within the degree programmes that are common.

8. Direct entry degree programmes should explore possibilities for multidisciplinary educational opportunities where this is feasible, through the development of modules targeted at healthcare professionals from other disciplines.

9. Opportunities should continue to be developed for access to registration in the other branches of the profession for registered nurses and midwives, through post-registration education programmes.

10. A comprehensive professional career development service should be provided for all nurses and midwives.

11. Continuing professional development should be incorporated into HR Management practices, including a comprehensive system of performance appraisal, personal development plans and peer review.

12. In recruitment practices, particular attention should be given to the possibility of joint appointments across the various career pathways. The potential for joint appointments should be explored and promoted wherever possible.

13. HR managers should work with nurse and midwife managers in all career pathways to increase the attractiveness of the profession for potential entrants.

14. Registered nurses and midwives should be required to produce evidence of professional development activities in line with guidelines to be agreed. These guidelines will include a description of the responsibilities of individual nurses and midwives and of managers in this area.

15. A comprehensive institutional framework should continue to exist and to be developed for the provision of post-registration educational and training.

16. National and regional support agencies should continue to exist, responsible for the strategic planning and development of the profession in line with the needs of the services and the evolving role of nurses and midwives within the services.

17. Universal access to professional development opportunities should be a key principle in the development of programmes.

18. Post-registration educational and training provision should continue to be developed in a manner that reflects the evolving needs of the service and the profession and, in particular, the career pathways within the profession.

19. The development and provision of professional development post-registration opportunities should be done with an emphasis on supporting nurses and midwives in the expansion of their practice in line with the framework for scope of practice and the needs of the services.

20. Particular attention should be paid to the development of professional development opportunities in the area of primary care where a lack of provision has been identified.

21. Post-registration educational opportunities should develop where appropriate on a multidisciplinary basis, integrating education for nurses and midwives in specialist areas with the provision of education for other health care professionals.

22. Nurses and midwives in all career pathways and at all levels of practice should be encouraged and supported in the development of succession planning and fast tracking initiatives, aimed at enhancing the competence profile of nurses and midwives in all areas and at ensuring that a pipeline of competent professionals exists capable of filling roles and posts as they become available in line with the needs of the services and of patients and clients.

23. Professional development opportunities should be made available for the development of management and leadership competencies in all career pathways.

24. Professional development opportunities should be made available for the development of expertise in the use and integration of ICT into the delivery of health care services by nurses and midwives.

25. Nurses and midwives should be provided with regular information and educational opportunities that build an understanding of the health care services, the public sector, standards of public accountability, governance, risk management and health economics, public private

partnerships and other themes that enhance their understanding of the context within which services are provided.

26. Continuing professional development should include education and training on cultural issues in the delivery of services, including an appreciation of the multi-ethnic nature of Irish society and the importance of sensitivity and understanding of cultural differences.

27. Nurses and midwives should be provided with access to post-registration training and educational opportunities on a multidisciplinary basis in areas that enhance their ability to make a contribution to the efficiency and effectiveness of the services.

28. Programmes in interprofessional education should be encouraged with a renewed emphasis on building into these programmes an evaluation of their effectiveness.

29. Local and regional providers of services in the area of post-registration professional development should collaborate with user of these services to assess local need and effectiveness.

30. A comprehensive professional development strategy should include the development of opportunities to prepare nurses and midwives to deliver meaningful inputs into the strategic planning of the executive functions of the health services, the development of healthcare policy and the development of performance management and monitoring arrangements. This will be aimed at ensuring that the profession of nursing and midwifery is capable of providing both the DoHC and the HSE with competent professionals capable of having a meaningful input at the highest levels.

Chapter 8 – A Strategy for the Professional Development of Nursing and Midwifery in Ireland – 2008 to 2017

8.1 Introduction

The aim of this chapter is to propose a strategy for the professional development of nursing and midwifery, based on the research described in this thesis, for the ten year period 2008 to 2017, in fulfilment of objective 13 of the research aims and objectives as outlined in chapter 4 (4.2).

The choice of a ten year period for the strategy is a pragmatic one. It is based on good practice in business and organisational strategic planning to set a realistic timescale within which the effectiveness of a strategy can be measured. It is also predicated on the basis of a rolling review each year, with substantial reviews in years 5 and 9. The strategy therefore, is not intended as a static plan but as a dynamic planning and development instrument that should change to meet changes in the environment.

The ten year period can also be related to the last ten years, since the publication of the Report of the Commission on Nursing (Government of Ireland, 1998). During those ten years much has changed in nursing and midwifery in Ireland. Almost all of the recommendations of the Commission on Nursing have been implemented. One notable exception is the passing of a new Nurses Act to replace the *Nurses Act 1985* (Government of Ireland, 1985) but at the time of writing plans are well underway to remedy this gap. The legacy of the Commission on Nursing, therefore, is there to be seen. The question now is what is the next step? What will nursing and midwifery feel and look like in ten years from now? These are questions that this strategy will attempt to answer.

The structure of the strategy as outlined in this chapter is based on the experience of strategic planning that has been developed in the National Council during the years 2001 to 2007. It follows standard business planning

templates but is adapted to the specific circumstances of nursing and midwifery. The elements of the strategy can be summarised as follows:

1. Analysis of the strengths, weaknesses, opportunities and threats (SWOT) facing the professions of nursing and midwifery in Ireland today – This is an essential preamble to the development of strategies to take advantage of the strengths, resolve the weaknesses, exploit the opportunities and avoid the threats.

2. Vision – This will state what nursing and midwifery should look and feel like in the health services of the future, and in particular in ten years time, at the end of the period of this strategy.

3. Mission statement – This will address the question what is the central role and purpose of nursing and midwifery in the health services?

4. Values – This suggests what the core values of the professions of nursing and midwifery should be, based on an understanding of the essence of nursing and midwifery[54] and their mission within the services.

5. Objectives – This will state what the long term objectives of the strategy should be in line with the expectations and requirements of all the major stakeholders. These objectives should reflect the underlying reasons for being involved in the delivery of professional nursing and midwifery services and should be related to the outputs and the outcomes that nurses and midwives seek to deliver.

6. Key Strategies - These are the rules and guidelines by which the mission and objectives may be achieved. The identification of the key strategies will be based on the SWOT analysis and will seek to build on the strengths, resolve the weaknesses, exploit the opportunities and avoid the threats.

7. Strategic Action Programmes – This provides an outline action plan that sets out how the key strategies will be implemented. It will cover issues

[54] See chapter 2 (2.7)

such as objectives, resources, time-scales, deadlines, and performance indicators.

8. Conclusion – Next Steps – This provides a brief outline of the next steps involved in generating ownership of the strategy at a national level and the importance of the negotiation and development process that will be required to implement it.

8.2 Strengths & Weaknesses, Opportunities and Threats (SWOT)

Based on the outcomes of the research, including the comments made by interviewees and participants in focus groups, the following is a summary of the principal strengths, weaknesses, opportunities and threats that are relevant for the development of a strategy for the professional development of nursing and midwifery (Table 8.1):

Table 8.1 – SWOT Analysis of Nursing and Midwifery in Ireland

Strengths **1.** Structures and policies **2.** Professional development **3.** Education **4.** Clinical credibility **5.** Workforce	**Weaknesses** **1.** Leadership **2.** Skill Mix **3.** Integration **4.** Service Development **5.** Capacity in the Community
Opportunities **1.** Structures and policies **2.** Professional development **3.** Education **4.** Legislation **5.** Workforce	**Threats** **1.** Identity **2.** Professional Development Capacity **3.** Recruitment and retention **4.** Capacity in the Community **5.** Clinical involvement

Strengths

The research in this thesis points to many significant strengths in nursing and midwifery in Ireland today. The principle strengths that emerged in the research can be summarised under the following headings:

1. **Structures and Policies**: The existence of a single structure for the management and delivery of healthcare in Ireland was seen as a very positive development by participants in this research (5.4; 5.5)[55], notwithstanding the criticisms that are made of some of the aspects of the delivery system and the way in which it was introduced. Overall, the HSRP and the reports and policy documents that underpin it, were welcomed and identified as a significant step forward for Irish health services (5.4; 5.5). For nursing and midwifery, a particular strength over the last ten years was the implementation of the recommendations of the Commission on Nursing (evidenced by many comments throughout chapter 6 and 7). This has been instrumental in revolutionising nursing and midwifery in Ireland, not least by the provision of a clear clinical career pathway, the role of the National Council, the creation of institutional frameworks for the development of the profession, the creation of the Nursing Policy Unit within the Department of Health and the reform and investment in education and professional development. (6.4; 6.5). The creation of HIQA was also welcomed as an important dimension in the accountability structures for the services (5.7; 5.8).

2. **Professional development**: The profile and provision of professional development for nursing and midwifery emerged from this research as a great strength for the profession. In particular the structures and frameworks that are in place and the expertise that has been built up (6.3) in the National Council (6.3; 7.2) and in the NMPDUs (6.3). This has resulted in clinical career pathways being clearly defined and implemented (6.3). The progress that has been made in professional development has been complemented by the development of a portfolio approach to career

[55] Numbers in brackets throughout this chapter point to sections in this thesis where evidence for the statements are to be found. This does not mean that these are the only source of evidence for the statement within the research.

planning (7.8). The recent work in professional development has built on the Scope of practice framework that was put in place in 2000 (6.6; 7.5). This framework has provided the professions with a solid platform upon which to expand their practice while still retaining their identity. The research also highlighted evidence of expanding practice for nursing and midwifery (6.6). In addition to initiatives in the expansion of practice, specialisation and advanced practice in nursing and midwifery has developed and is being implemented proactively throughout the service (6.3). Finally, the research also highlighted the important benefits that will be derived from the introduction of legislation providing for the involvement of nurses and midwives in the prescription of medical preparations (6.4) and the creation of the structures necessary to make this happen (6.4).

3. **Education**: The substantial investment that has been made in education for nurses and midwives in recent years was identified by this research as a major strength for the professions. In particular the introduction of the pre-registration degree programme for all the branches of the profession (7.6) and the development of enriched post-registration education opportunities (7.7). The research also pointed to the value of the development work that is currently underway in the area of post registration education (7.7). In addition to the formal education structures, there is in place now a wide range of opportunities for CPD (7.8) to support professional development. The research also identified the creation of the Centres for Nurse Education (7.8) as being of great importance in the provision of important skills development and training.

4. **Clinical credibility**: The research provided evidence of the continued credibility that the professions of nursing and midwifery enjoy within the health services in Ireland (6.6; 6.7; 7.2). This is evidenced by the good working relationships that exist between nursing and midwifery and medical consultants (6.6) and the predominantly positive image of the professions that is held by many service managers (6.3; 6.5; 7.2; 7.3; 7.4) The expansion of nursing and midwifery practice, the development of specialists and advanced practice and the increase in the number and variety of nurse/midwife led

services being developed in acute and primary settings (6.6) are all reasons why the professions enjoy an enhanced reputation and credibility with the health services. This is a strength that is pervasive throughout all of the research, notwithstanding the weaknesses and threats that are also identified.

5. **Workforce:** In addition to having achieved a considerable degree of respect and credibility as a clinical profession, nursing and midwifery are also seen by participants in this research as a committed, flexible and adaptive workforce (6.5; 7.2). This comes through in many instances within the research, notwithstanding some of the difficulties that are also identified. On the whole, the professions are regarded as being populated by a caring, committed workforce.

Weaknesses

The research also identified a number of important weaknesses for the professions. The most important of these can be summarised as follows:

1. **Leadership**: Ten years after the publication of the Report of the Commission on Nursing, this research echoes its findings on the question of leadership in nursing and midwifery (3.3). The research points to a clear dearth of leadership in the professions (6.5; 7.2; 7.3; 7.4). This lack of leadership manifests itself in many ways but perhaps most importantly as a lack of communication, coordination and integration in nursing and midwifery across divisions, institutional settings and grades (6.5; 7.4). One of the results of this lack of leadership is a lack of professional identity and of clear direction in nursing and midwifery (6.5; 7.2; 7.3; 7.4) and a lack of voice and credibility at the decision making table (6.5). The research also highlighted that there continues to exist within nursing and midwifery a negative, destructive culture of bullying and divisiveness (7.4). The research also showed that because of this lack of leadership and professional identity, there continued to be a low level of participation in and availability of CPD opportunities for staff nurses and midwives (National Council, 2004d) (7.8), and this is so in spite of the significant increase in

provision. Lack of professional identity and leadership also manifests itself in a lack of research capacity and competence within the professions (7.3; 7.4), although progress is being made in this area though the implementation of the Research Strategy (DoHC, 2003f). The research also pointed to a slow uptake of opportunities for joint appointments (6.3), the development of which will require strong leadership across the academic / clinical divide. The research also pointed to the negative influence of trade unions within the profession, promoting resistance to change and creating bitter divisions between nursing and midwifery management and staff and undermining the role of the Director of Nursing (6.3). Finally, while the research welcomed the fact that there existed a post of Chief Nursing Officer with a team of nursing advisors within the DoHC, their role and function remained unclear and undefined in the context of the HSRP (6.5). The impact of this role has yet to be felt.

2. **Skill Mix –** The research emphasised the importance of skill mix in the context of the recruitment and retention of nurses and midwives (3.3; 7.5). Experience from the United States, Canada and the United Kingdom pointed to the importance of creating attractive working environments that act as magnets to staff to work. This requires investment in skill at all levels and across all grades and the development of complementarity within and between roles. The question of skill mix is particularly important in the development of multidisciplinary teams in acute and primary care settings (6.5; 6.6; 6.7; 7.3; 7.4; 7.5). Recent demands for the introduction of a 35 hour week for nurses and midwives and the creation of a Commission to review the 35 hour week, have raised the importance of and the need for skill mix developments (6.3). This is therefore an unresolved issue in nursing and midwifery.

3. **Integration –** The results of this research emphasised the importance of integration as a key theme in developing health services for the future. In particular, the research highlighted that one of the weaknesses of the new organisational structures was the creation of separate pillars (appendix 1 and 2) for primary, continuing and community care (PCCC) and acute care

(NHO) (5.4; 5.5; 5.6). This only served to emphasise lack of integration within the structures of the HSE itself and makes it difficult to achieve the objectives of the Transformation Programme (HSE, 2006b), which has at its centre the concept of a shift towards community based services and the creation of an acute / primary care continuum. The research also pointed to the lack of integration across the professions (6.3; 6.4; 6.5;) as has been already highlighted as part of the weakness in leadership. Finally, the research also pointed to the confusion that exists about the nature of the changes in the role of the DoHC (5.4). This confusion does not serve well the need for an integrated approach to planning and delivery.

4. **Service Development –** This research emphasised the importance of service development as an important part of the changes in organisational structures in the future (5.5). In particular it emphasised the need to put the patient / client at the centre of service development (5.8). The research emphasised the need for an integrated service development framework (2.3.3; 6.3; 6.4) for nurse and midwife led services and the provision of support and training in service development for nurses and midwives (2.5). This is an essential corollary to the roll-out of the Transformation Programme (HSE, 2006b).

5. **Capacity in the Community –** One of the national goals of the health services is to ensure the system has the capacity to deliver timely and effective healthcare services (1.3.1). However, the primary research revealed concerns about capacity problems creating pressures within the system (5.6). Given the emphasis on integration of services and the shift to the community, concerns have been raised about nursing and midwifery capacity within the community. In the area of mental health services, the document *Vision for Change* (Government of Ireland, 2006) pointed to the fact that there were not enough psychiatric nurses in the community to meet the needs arising from a continued shift of services away from institutional settings (1.4). The report also pointed to the need to build up Community Mental Health Teams in the Community, which will require the creation of

multidisciplinary community based capacity (2.2). The *Transformation* Programme (HSE, 2006b) emphasises the importance of the Primary Care Teams (PCTs). If these are to function correctly they will also require capacity building in the community (1.3.2). A mapping exercise conducted by the HSE estimated that a total of 500 PCTs would be required and that the minimum core team members would include: GPs, practice nurses, occupational therapists, PHNs, physiotherapists, speech and language therapists, social workers and home help (1.3.2). Also included in this team should be general nurses and midwives, nurse and midwife specialists and advanced nurse and advanced midwife practitioners and other support workers. The intention is that these teams would be linked by social care networks. A total of 130 such networks would be required, linking 3-5 teams for population bases of 30,000 to 50,000 people (1.3.2). Nurses and midwives are important elements of PCTs (5.10; 6.8) and the challenge of building capacity to meet this need is very great. The research also recognised that in order to meet capacity requirements, it is likely that there will be a need to increase the capacity of private sector provision (5.6).

Opportunities

The research highlighted a number of opportunities that present themselves for the profession of nursing and midwifery in the future. These include:

1. **Structures and Policies** – The HSE *Transformation Programme* (HSE, 2006b) presents nursing and midwifery with a significant opportunity to have a major impact on shaping the health services of the future (5.6; 5.8; 6.2; 6.8)**.** This provides an ideal opportunity for the development of innovative nurse and midwife led services (6.5) and playing a central role in setting up and ensuring the effectiveness of the PCTs (6.8). The existence of the Nursing Policy Division in DoHC (6.5) and the Nursing Unit within the HSE (6.4; 6.5) also provide nursing and midwifery with the potential to have access to policy formulation and service planning at the highest level. The introduction of prescribing for nurses and midwives (6.4) also presents an opportunity for the profession to add an important new

dimension to its practice in a way that meets the needs of patients and clients. The Commission set up to review the possibility of introducing a 35 hour week (6.4) will also present an opportunity for nurses and midwives to look at their work practices and the skill mix issues in their work settings to provide innovative solutions to achieving the target of a 35 hour week without significant additions to cost in terms of whole time equivalents. The emergence of active representative patient and consumer groups (5.8; 5.9) also present the profession with the opportunity to engage with them in a manner that emphasises the patient centred nature of nursing and midwifery care. The emergence of the National Treatment Purchase Fund and other Public Private Partnership initiatives within the services (5.6) provide nursing and midwifery with an opportunity to ensure that professional development extends beyond the public sector to encompass all of the profession, regardless of work settings.

2. **Professional Development –** The research highlighted the progress that has been made to date in the development of a wide range of professional development opportunities for the profession (2.5; 6.2; 7.8). The research also highlighted the importance of the role of the National Council. The National Council was set up to promote the role of nursing and midwifery in line with service need in public, voluntary and private settings. This emphasis on service need has been a hallmark of the work of the National Council. The continuance of this work presents opportunities to continue to provide leadership in the development of nursing and midwifery in a manner that is responsive to the needs of the service and of patients and clients. The research also emphasised the importance of the emergence of Integrated Care Pathways (5.8; 6.8) as a basis for both professional and service development. Another significant opportunity for the professions was identified as the emerging increased volume of multidisciplinary cooperation (6.7) in service and in education. The research emphasised the importance and value of Joint appointments (7.8) as significant opportunities for the profession to develop a strong sense of professional identity and a strong culture of academic and evidence based clinical practice. This opportunity is enhanced by the evidence of increasing

integration of universities and hospitals networks (5.5). Finally, the research also emphasised the important opportunities that presented themselves as a result of the ongoing implementation of the Research Strategy (DoHC, 2003f) (7.4).

3. **Education –** The research highlighted many opportunities for the profession of nursing and midwifery as a result of the major investment that has taken place in education for nurses and midwives over the last ten years. The growth in education activity in Universities and Institutes of Technology (7.6; 7.7; 7.8; 7.9) and in the Centres for Nurse Education (7.8) provide a rich vein of development potential for the profession, not least of all in the development of academic competence and research capacity. The potential for multidisciplinary education (7.6; 7.7; 7.8; 7.9) and the emerging volume of post-registration education provision (7.7) also provides a wide range of opportunities.

4. **Legislation –** The Government is expected to introduce a new Nursing and Midwifery Act in the near future. This presents an opportunity to provide for the regulation and development of the profession in a manner that capitalises on the strengths of the progress that has been made since the Commission on Nursing (Government of Ireland, 1998) (2.1; 2.3.1). International best practice in this area points to the need for enabling and flexible legislation that creates the conditions for the professions to develop in a manner that is responsive to the needs of the service and of patients and clients (3.4.1; 3.4.2). One of the principle aims of the legislation will be to provide for the protection of the public through strong regulatory structures and processes. It is important however that the legislation should also distinguish between this function (which is the remit of the Regulatory Body) and the proactive development of the profession (which is the remit of the services). Legislation should not hamper the ability of the professions to develop in line with the needs of the service.

5. **Workforce –** The profession of nursing and midwifery enjoys a very good reputation within the profession and the workforce is highly regarded. The

research identified a great deal of good will within the profession and willingness to adapt to meet the challenges of the future (6.5; 7.2). This presents a major opportunity to the leaders of the profession to take advantage of this good will as a force for development.

Threats

The research identified a number of potential threats that could undermine the potential of the professions to fulfil their destiny within the health services of the future. These include:

1. **Identity –** One of the biggest threats to the professions is the potential for a loss of professional identity in the health services of the future. The research pointed to the importance of nursing and midwifery remaining true to itself as it developed along the clinical career pathway and the development of nursing and midwifery led services (6.2 – 6.7). This raises the importance of nursing and midwifery maintaining contact with the essence of nursing (2.7) as it develops. Another significant threat to the protection of the identity of the professions comes from within the professions in the form of divisiveness within nursing and midwifery (6.5; 7.4). This can come about because of a lack of leadership and empowerment (3.3) or as a result of industrial unrest not managed properly. The research also pointed to the capacity that exists within the profession to be destructive, negative and litigious (7.4). This is something that had already been highlighted by the Commission on Nursing (Government of Ireland, 1998) and, based on this research, it still persists. The research also pointed to the negative impact of trade unions that have promoted an industrial relations culture to the detriment of a professional identity for nurses and midwives (6.3). The lack of professional identity is frequently expressed and manifested in disempowerment of nurses and midwives. Research indicates that nurses and midwives continue to experience significant disempowerment within the services (2.4.2; 7.4). The continuance of this will amount to a significant threat to the development of an empowered workforce, confident and clear about its key role as central

players in the development and delivery of the services of the future. Tackling these threats will need to be part of the development strategy that is put in place.

2. **Recruitment and Retention –** The professions face significant threats from the challenge to recruit and retain staff into the future (3.2; 6.4; 7.5). International research (3.2) confirms that this is not just a threat in Ireland. It is a major challenge to policy makers, service planners and service managers however to ensure that the capacity exists to meet the service needs of the future by recruiting and retaining a cohort of competent nursing and midwife professionals. The continued development and implementation of strategies in this area will be important.

3. **Professional Development Capacity –** One of the recommendations of the *Prospectus Report* (DoHC, 2003b) was that the functions of the National Council should be divided and transferred to the HSE and An Bord Altranais. In effect this amounts to dissolution of the National Council and a division of its activities between two organisations. This presents a threat to nursing and midwifery in public, voluntary and private care settings, in that there is the potential that the expertise in professional development could be lost to the professions. It also presents a threat to the development of appropriate services in line with the evolving needs of the service, of patients and clients. The research highlighted in many ways the invaluable contribution that the National Council has made to the development of the professions and the services in a manner that is highly responsive to service, patient and client needs. Thus for example in encouraging the professions to adapt to role change (6.3); in providing leadership to the professions (6.3); in facilitating the development of roles within frameworks of practice (6.5); in promoting the integration of services (6.7; National Council, 2006f); in the development of new skills that are required (7.2); in building opportunities for and participation in CPD (7.8) and in promoting opportunities for interdisciplinary education (7.9).

4. **Capacity in the Community –** Because of the central importance of building community based services, encouraging a shift away from acute services and developing a service continuum between acute and primary care, the lack of community based capacity within the profession is a significant threat (1.3.1; 1.3.2; 5.6; 5.8; 5.10).

5. **Clinical Involvement –** As the process of health service reform progresses, it is important that the decision-making is not driven solely by economic based efficiency considerations. This can result in cuts and changes being made that are not in the best interests of patients and clients and of the services. As service managers come under increased pressure to deliver accountable and budget-conscious services, there is a threat that the axe will be wielded without full possession of the facts about the impact of certain decisions. It is essential that clinical involvement in decision making about resource allocation is further developed and extended at national, regional and local levels (5.5; 5.6; 5.7). This includes also decision making about the structures and processes that will be in place within the services of the future for the professional development of nursing and midwifery. As organisation change and structural reform develops pressure has built up for the Nurses and Midwives Act to define the role of regulation, which is fundamentally about the protection of the public. Regulation by its nature is legalistic and works in a culture that is very different from the developmental, innovative culture of professional development. The important regulatory role should not impede the dynamic development of the professions that is required. Careful consideration needs to be given to the involvement of the clinical expertise that has been built up over the last ten years in the development of the profession (3.4; 6.8; 7.8; 7.10).

That concludes the SWOT analysis of the profession of nursing and midwifery based on the results of the research presented in this thesis. These considerations provide the material for the development of appropriate responses in the form of strategies and action plans to build on the strengths, tackle the weaknesses, exploit the opportunities and avoid the threats.

As we look into the future of the health services from the perspective of this SWOT analysis, it is time now to reflect on what nursing and midwifery should be like in 10 years time as a result of implementing a strategic development plan. This is the purpose of the next section of this chapter.

8.3 Vision

This section of this chapter will address the questions – what should nursing and midwifery in Ireland look and feel like in 10 years time? What will it be like to be a nurse and midwife in Ireland in 10 years time? The answer to these questions will provide a vision of what this strategy for the professional development of nursing and midwifery aspires to achieve.

Based on the results of the research presented in this thesis, the following elements constitute the principal dimensions of the vision for nursing and midwifery in the health services in Ireland by the year 2017:

1. The profession of nursing and midwifery will enjoy a strong professional identity. Nurse leaders will be prominent in the formulation of policy for the health services and in the development of service plans to implement that policy. Communication and coordination within the profession will create the platform for the generation of credible public positions that articulate the contribution of the profession to the health services and act as an advocate on behalf of patients and clients of the service. Nursing and midwifery will be seen as a desirable career option for individuals and will develop a reputation for retaining staff.

2. Nurses and midwives will enjoy access to rich and rewarding educational and professional development opportunities adapted to their area of practice. Educational and development provision will be predominantly interdisciplinary in nature, involving interaction with other professions and support workers.

3. Nurses and midwives will work either as leaders or members of care teams in every healthcare setting. This will involve an identification of the specific contribution that each member of the team makes to the achievement of the goals of the service. Increasingly these teams will involve a wider mix of skills aimed at ensuring that each of the members of the team maximises their specific contribution.

4. Nurses and midwives will be highly visible within the community as leaders of nursing and midwifery services and as members of primary care teams involving other professionals and support services. This will include the development of nurse and midwife led clinics and home based services. This will include nurses and midwives at every stage of the clinical career pathway, from generalist to specialist to advanced practice.

5. Nurses and midwives at generalist, specialist and advanced practice levels, will complement and augment the work of GPs in the delivery of patient centred services, frequently within the patient's own home and family setting. The nurse and midwife will be a resource to families and communities in addressing all their health needs, including referring individuals on to other professional services in primary and acute settings. Nurses and midwives will be the main coordinators of care in the community.

6. Nurses and midwives will occupy a central role in the education of individuals, their families and the community in the promotion of good health. This will be seen to deliver measurable outcomes in areas such as lifestyle diseases. This will complement the emergence of a more informed client / patient, interested in being involved in managing their own health and well-being.

7. Nurses and midwives will continue to occupy a central role in the development of acute hospital services, including the development of generalist, specialist and advanced practice in a manner that ensures that the patient remains at the centre of acute care provision. The nurse and

midwife will play a central role in coordinating the inputs of other healthcare professionals. The nurse and midwife will also ensure that continuity of care is provided across the acute / primary care divide by following up with the patients in their own homes and coordinating with community based care services to deliver follow-up care.

8. There will be a significant increase in the use of joint appointments along the career pathway for nurses and midwives. This will involve nurses and midwives being involved in research, education and clinical practice increasingly on the basis of shared contracts between different institutional settings.

8.4 Mission Statement

In this section of this chapter an attempt is made to define the central role and purpose of nursing and midwifery in the Irish Health Services – this is what is understood by the phrase 'Mission Statement'. This is defined based on the needs of the service as defined in this research and the essence of nursing (2.7). This can be summarised as follows:

Nurses and midwives in Ireland provide a comprehensive range of care services to individuals and their families, across all institutional settings, in close cooperation with other healthcare professionals and support workers. The provision of this care is inspired by the following considerations:

1. **Person Centred –** Nursing and midwifery provide person-centred care to individuals and their families based on an understanding of their specific needs. In doing this the nurse and midwife acts at all times in the interests of the person.

2. **Relationship based –** In the provision of patient centred care, nurses and midwives build up a relationship of empathy with the individual, based on respect and consideration for the individual and animated by the values of equality, esteem, meaning, safety and trust.

3. **Holistic –** The care provided by the nurse and midwife focuses on the totality of the person, physical, psychosocial, emotional. It is also sensitive to the cultural circumstances of the individual. It is based on the values of respect for diversity.

4. **Education and Information –** The care provided by the nurse or midwife is focused on promoting self reliance and independence in the individual. This includes providing them with the wherewithal to be able to become independent. It extends beyond the individual to their families and communities in order to ensure that support mechanisms are empowered to assist.

5. **Coordination –** Nurses and midwives ensure that the individual has access to whatever is required to assist them to achieve self-reliance and independence. This includes coordinating the inputs of other professionals, making technology available as required and taking charge of environmental management issues that affect the well being of the individual.

6. **Continuity –** Nurses and midwives will provide care in whatever setting best meets the needs of the individual and of the services. This will include acute and primary settings and will involve spanning the boundaries of both by following the patient throughout the system. In providing this care, the nurse and midwife will act as part of a multidisciplinary team, either as member or as leader, as needed.

7. **Knowledge and Skills –** Nurses and midwives invest in their own education and development, fully aware that clinical wisdom comes about as a result of experience combined with knowledge and understanding. Competence development is an essential ingredient in the accountability values that nurses and midwives build into their professional practice. Nurses and midwives see themselves as professionals who combine science and art in the interests of the individual under their care. This will

also include the development of specialist knowledge aimed at providing an enhanced level of care to target groups.

8.5 Values

The values that govern the work and conduct of nurses and midwives in their professional lives are outlined in the *Code of Professional Conduct for each Nurse and Midwife* (An Bord Altranais, 2000c). The *Code* provides nurses and midwives with a framework within which to make decisions and is intended also to promote high standards of professional conduct. The values contained in the code reflect the essence of nursing (2.7) and can be summarised as follows:

1. **Accountability** – Nurses and midwives are accountable for their own practice.
2. **Safety** – The safety of those in their care is of paramount importance.
3. **Confidentiality** – Nurses and midwives do not divulge information about those in their care.
4. **Trust** – Nurses and midwives do not betray the trust placed in them by patients and clients.
5. **Information** – Nurses and midwives provide patients with information on their care in an appropriate manner.
6. **Sexual propriety and respect** – Nurses and midwives do not make sexual advances to those in their care.
7. **Competence** – Nurses and midwives base their professional judgement on their competence, which they have a duty to maintain. They also acknowledge when appropriate the limits of their competence.
8. **Conscientious** – Nurses and midwives make known any conscientious objections they may have to practices.
9. **Shared responsibility** – Nurses and midwives share the responsibility for care with other colleagues and must ensure that workload pressures do not jeopardise that care.

10. **Educate –** Nurses and midwives have a duty to educate junior staff and to ensure that responsibilities are not delegated beyond levels of competence.
11. **Responsible –** Nurses and midwives are responsible and accountable for the care provided by students under their supervision.
12. **Cooperation –** Nurses and midwives cooperate with healthcare professionals and others to promote the health of the public.
13. **Life –** Nurses and midwives work to preserve human life and, when death is imminent, to ensure that the patient dies with dignity.
14. **Public statements –** Nurses and midwives make it clear when speaking in public whether they are expressing a personal or a professional opinion.
15. **Non-commercial –** Nurses and midwives do not use professional qualifications to promote commercial products.
16. **Gifts –** Nurses and midwives do not accept gifts or favours that could be interpreted as wishing to exert undue influence or obtain preferential treatment.
17. **Personal Health –** Nurses and midwives take precautions to ensure that their state of health enables them to be competent in fulfilling their duties. Abuse of drugs and alcohol adversely affects that competence.
18. **Research ethics –** Nurses and midwives have a responsibility to adhere to high standards of ethical practice in conducting or participating in research.

All of these values continue to be relevant in the context of this strategy.

8.6 Objectives

The long term objectives of the professions of nursing and midwifery must be to meet the expectations and requirements of all the major stakeholders in the health services, i.e. individual patients and clients, the general public, professional colleagues and co-workers, employers, policy makers and the Government. The objectives therefore, must reflect the reason for the existence of the professions and their mission within the health services. The following

set of objectives seeks to articulate what those expectations and reasons for existence are.

In the context of the current reform of the health services in Ireland, it is possible to identify three overarching objectives for nursing and midwifery:

1. Improve the quality of care provided to patients and clients.

2. Improve access to care for patients and clients.

3. Ensure the capacity to deliver timely and effective healthcare services.

The achievement of these overarching objectives implies a further set of objectives for nursing and midwifery in particular:

1. To act as the principal coordinator of care on behalf of the patient or client and to ensure that the care provided is focused on the needs of the individual in both primary and acute settings.

2. To expand the scope of practice of nursing and midwifery in a manner that is responsive to the needs of patients and clients and enhances the contribution of nursing and midwifery to the achievement of healthcare outcomes. This will include the management of patient caseloads and the development of nurse / midwife led clinics, involving generalist nurses and midwives, CNS/CMS and ANP/AMP as appropriate.

3. To enhance the levels of cooperation between nursing and midwifery and other healthcare professionals and support workers in the context of multidisciplinary teams.

4. To increase the presence of nursing and midwifery in the community based on health need. This implies a patient-centred, health focused, holistic nursing orientation to practice that is complementary to existing models of care delivery. It is not based on physician replacement, but on health need. It may involve providing alternatives to physician based

services and may avoid the need for patients and clients to have access to physicians or acute services.

5. To promote a positive understanding of health and approaches to healthy living in patients, clients, their families and communities. This involves providing advice, information and education and is focused on empowering the individual to manage their own care and wellbeing.

The achievement of these objectives will serve to meet the expectations and requirements of the key stakeholders within the health services and will ensure that the specific contribution of nursing and midwifery to the development of the healthcare services of the future is maximised.

In order to achieve these objectives however, it will be necessary to put in place a number of strategies. The identification of these key strategies is the focus of the next section.

8.7 Key Strategies

This section will identify the key strategies that need to be put in place to achieve the objectives of nursing and midwifery within the healthcare services while taking advantage of the strengths of the professions, tackling the weaknesses, exploiting the opportunities and avoiding the threats.

The following strategies are proposed:

1. **Provide strategic coordination and leadership for the professions of nursing and midwifery –** This includes:
   - **a.** Devising ways to fill the leadership gap that exists within the professions
   - **b.** Building mechanisms for coordination and communication across the professions
   - **c.** Building professional identity of nursing and midwifery
   - **d.** Promoting innovative approaches to professional development
   - **e.** Promoting the use of joint appointments
   - **f.** Devising innovative ways of communicating with staff nurses and midwives to promote and deepen their understanding of the essence of nursing and midwifery.

2. **Contribute to the integration of healthcare services in cooperation with other healthcare professionals and support workers –** This includes:
   - **a.** Promoting and actively cooperating in initiatives aimed at increasing the integration of services at national, regional and local levels
   - **b.** Promoting an understanding within the services of the role that nursing and midwifery can play in achieving greater integration of services
   - **c.** Promoting nursing and midwifery participation in multidisciplinary teams in acute and primary care settings

d. Developing posts within service plans for appointments that span the boundaries between acute and primary care services.

3. **Devise and implement national, regional and local skill mix development plans –** This includes:
   a. Building awareness and understanding of how skill mix initiatives can contribute to improving the quality and efficiency of care in different care settings
   b. Developing channels of communication with regulatory bodies and representative association of other healthcare professionals and support workers to promote innovative approaches to skill mix

4. **Develop nursing and midwifery services –** This includes:
   a. Identifying priority service development areas in partnership with service managers at national, regional and local levels
   b. Promoting an understanding of how nursing and midwifery led services can contribute to the quality and efficiency of the services
   c. Supporting initiatives in primary and acute services for the development of services, either led by nurses and midwives, or with nurse and midwife participation, as appropriate.
   d. Cooperate with other healthcare professionals and support workers in the development of appropriate services at national, regional and local level.

5. **Build nursing and midwifery capacity in the community –** This includes:
   a. Cooperating with national, regional and local service managers in the identification of health needs that can be met by nurses and midwives working in the community
   b. Engaging with national, regional and local service managers in mapping the areas in the community where greatest need for nursing and midwifery presence exists

c. Developing nursing and midwifery follow-up services from acute healthcare settings, reaching out into the community, following up on patient needs

d. Promoting within nursing and midwifery the concept of the nurse / midwife in the community

e. Influence the service planning process to ensure priority is given to increasing the presence of nurses and midwives in the community

f. Encouraging a shift away from the provision of services in acute settings to the delivery of nurse and midwife led services in the community.

6. **Review and renew the strategic plan for the professional development of nursing and midwifery –** This strategic plan requires initial discussion at national level between key stakeholders in order to achieve buy in. Thereafter regular reviews of this strategy, including a review of the priorities identified within it in the light of changing circumstances within the health services and the changing needs of patients and clients.

8.8 Strategic Action Programmes

In order to implement the strategies outlined in the previous section, it will be necessary for concerted action by the key stakeholders involved in the health services. This will include –

Table 8.2 – Action Programmes, Stakeholders and Indicators

Action Programmes	Stakeholders	Measure of Success
1. Provide strategic coordination and leadership for the professions of nursing and midwifery	DoHC, HSE, ABA, National Council, Education Institutions, NMPDUs, Directors of Nursing and Midwifery	**1.** Action plans are in place to fill the leadership gap that exists within the professions **2.** Mechanisms for coordination and communication across the professions are developed **3.** Professional identity of nursing and midwifery is promoted through a series of strategic interventions

Action Programmes	Stakeholders	Measure of Success
		4. Professional development for nurses and midwives is prioritised in service planning and policy **5.** Joint appointments are evident throughout the professions. **6.** The essence of nursing and midwifery is promoted through a series of strategic communications exercised with the professions.
2. Contribute to the integration of healthcare services in cooperation with other healthcare professionals and support workers	HSE, National Council, NMPDUs, Directors of Nursing and Midwifery	**1.** Strategic action plans are agreed to promote the integration of services at national, regional and local levels **2.** Communications plans are in place throughout the services to promote the role that nursing and midwifery can play in achieving greater integration of services **3.** Nationwide plans are in place to build the participation fy nursing and midwifery participation in multidisciplinary teams in acute and primary care settings **4.** Service plans make provision for making appointments that span the boundaries between acute and primary care services.
3. Devise and implement national, regional and local skill mix development plans	DoHC, HSE, National Council, NMPDUs, Directors of Nursing and Midwifery	**1.** Communications, training and development plans are in place aimed at building awareness and understanding of how skill mix initiatives can contribute to improving the quality and efficiency of care in different care settings **2.** Detailed discussions take place with regulatory bodies and representative association of other healthcare professionals and support workers to promote innovative approaches to skill mix
4. Develop nursing and midwifery services	HSE, National Council, Education Institutions, NMPDUs, Directors of Nursing and Midwifery	**1.** Priority service development areas are identified in partnership with service managers at national, regional and local levels **2.** Communications, training and development initiatives are in place aimed at promoting an understanding of how nursing and midwifery led services can contribute to the quality and efficiency of the services **3.** Service plans provide for the support of initiatives in primary and acute services for the development of services, either led by nurses and midwives, or with nurse and midwife participation, as appropriate.

Action Programmes	Stakeholders	Measure of Success
		4. Cooperate with other healthcare professionals and support workers in the development of appropriate services at national, regional and local level.
5. Build nursing and midwifery capacity in the community	HSE, National Council, Education Institutions, NMPDUs, Directors of Nursing and Midwifery	**1.** Cooperation mechanisms exist with national, regional and local service managers in the identification of health needs that can be met by nurses and midwives working in the community **2.** Nurses and midwives engage with national, regional and local service managers in mapping the areas in the community where greatest need for nursing and midwifery presence exists **3.** Nursing and midwifery follow-up services from acute healthcare settings, reaching out into the community, following up on patient needs, are developed. **4.** Strategic communications and promotion exercises exist t promote within nursing and midwifery the concept of the nurse / midwife in the community **5.** Service plans give priority to increasing the presence of nurses and midwives in the community **6.** Incentives exist to encourage a shift away from the provision of services in acute settings to the delivery of nurse and midwife led services in the community.
6. Review and renew the strategic plan for the professional development of nursing and midwifery	DoHC, HSE, ABA, National Council, Education Institutions, NMPDUs, Directors of Nursing and Midwifery	This strategic plan requires initial discussion at national level between key stakeholders in order to achieve buy in. Thereafter regular reviews of this strategy is required, including a review of the priorities identified within it in the light of changing circumstances within the health services and the changing needs of patients and clients.

8.9 Conclusion – Next Steps

The next steps in this process involve the generation of ownership of the outcomes of the research. This will require detailed engagement with the leaders of the services, at executive and policy level, and the creation of structures for coordination and communication within the professions. It will also require the dissemination of the messages of the research throughout the profession through the means of publications, seminars, workshops and conferences. The adoption of this strategy will require further detailed negotiation and development.

An important dimension of strategic planning is that of timing. It is important to have a clear time frame for a strategy as this will provide a sense of purpose and will define the urgency with which tasks need to be tackled. With this in mind, the strategy for the professional development of nursing and midwifery should be implemented over a 10 year time frame with review points throughout the period. The detailed indicators for each year need to be negotiated with the individual stakeholders. At the end of year three, it should be revised and a new five year strategy should be devised. This should provide the opportunity for a rolling dynamic strategic development process to be introduced into the planning and development of the profession in Ireland. This dynamic approach to strategic planning for the profession is required in order to adapt to the changes that will occur at a fast pace within the health services of the future. Details of the timing of specific elements of the strategy will be the subject of the negotiation and development involved in the next steps.

This research does not pretend to be complete; by its very nature it needs to be constantly refreshed and updated. It is, however, an important step along the way to building a future for the professions of nursing and midwifery within a changing health service that takes advantage of the richness of the role the professions can play. But it should not remain cast in stone; it should evolve and develop, adapt and change.

References

Advisory Committee on Health Human Resources (2000), *Nursing Strategy for Canada*, Advisory Committee on Health Human Resources, Canada, http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2000-nurs-infirm-strateg/index_e.html (Accessed 14th August 2007).

Aguinaldo, J.P. (2004), Rethinking the Validity of Qualitative Research from a Social Constructionist Perspective, *The Qualitative Report,* 9(1): 127-136.

Aiken, L. (1995), Transformation of the Nursing Workforce: The Shortage is in Properly Educated and Utilised Nurses, *Nursing Outlook,* 43: 201-209.

Aiken, L., Smith, H., Lake, E. (1994), Lower Medicine Mortality among a set of Hospitals known for Good Nursing Care, *Med Care*, 32(5): 771-787.

Aiken, L.H., Havens, D.S. & Sloane, D.M. (2000), The Magnet Nursing Services Recognition Programme: A Comparison of Two Groups of Magnet Hospitals, *American Journal of Nursing,* 100(3): 26-36.

Aiken, L.H., Clarke, S.P., Cheung, R.B., Douglas, M.S., Jeffrey, H.S. (2003), Educational Levels and Surgical Patient Mortality, *Journal of the American Medical Association,* 290(12): *ProQuest Nursing Journals,* 1617-1623.

An Bord Altranais (1994), *The Future of Nurse Education and Training,* An Bord Altranais, Dublin.

An Bord Altranais (1997), *Continuing Professional Education for Nurses in Ireland: A Framework,* An Bord Altranais, Dublin.

An Bord Altranais (2000a), *Scope of Nursing and Midwifery Practice Framework, An* Bord Altranais, Dublin.

An Bord Altranais (2000b), *Review of Scope of Practice for Nursing and Midwifery, Final Report,* An Bord Altranais, Dublin.

An Bord Altranais (2000c), *Code of Professional Conduct for each Nurse and Midwife*, An Bord Altranais, Dublin.

An Bord Altranais (2001), *Guidelines for Midwives (*3rd ed.)*,* An Bord Altranais, Dublin.

An Bord Altranais (2005a), *Annual Report 2005*, An Bord Altranais, Dublin.

An Bord Altranais (2005b), Title Changes to the Division of the Register, *An Bord Altranais News,* 17(1), Dublin.

An Bord Altranais (2005c), *Five Points Project*, An Bord Altranais, Dublin*,* http://www.nursingboard.ie/en/spon-five_points.xspx (Accessed 15th August 2007).

An Bord Altranais (2007a), *Nurses Rules 2007*, An Bord Altranais, Dublin.

An Bord Altranais (2007b), *Requirements and Standards for Education Programmes for Nurses and Midwives with Prescriptive Authority,* An Bord Altranais, Dublin.

An Bord Altranais (2007c), *Practice Standards for Nurses and Midwives with Prescriptive Authority,* An Bord Altranais, Dublin.

An Bord Altranais (2007d), *Decision Making Framework for Nurses and Midwives with Prescriptive Authority,* An Bord Altranais, Dublin.

An Bord Altranais (2007e), *Collaborative Practice Agreement for Nurses and Midwives with Prescriptive Authority,* An Bord Altranais, Dublin.

An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery (2005), *Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products - Final Report,* An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery, Dublin.

Antrobus, A. and Kitson, A. (1999), Nursing Leadership: Influencing and shaping health policy and nursing practice, *Journal of Advance Nursing,* 29(3): 746-753.

Arksey, H. & Knight, P. (1999), *Interviewing for Social Scientists - An Introductory Resource with Examples,* Sage, London.

Australian Nursing and Midwifery Council (2004), *Nurse Practitioner Standards Project: Report to the Australian Nursing and Midwifery Council*, ANMC, Dickson, ACT.

Barr, H. (2003), *Interprofessional Education: Today, Yesterday and Tomorrow - A Review,* Commissioned by the Learning and Teaching Support Network for Health Sciences and Practice (LTSN) for the UK Centre for the Advancement of Interprofessional Education (CAIPE).

Barrington, R. (1987), *Health Medicine and Politics in Ireland 1900 to 1970*, IPA, Dublin.

Begley, C.M. (2002), Great Fleas have little Fleas': Irish Student and Midwives Views of the Hierarchy in Midwifery, *Journal of Advanced Nursing*, 38(3): 310-317.

Begley, C.M., O'Boyle, C., Carroll, M., Devane, D. (2007), Educating Advanced Midwife Practitioners: A Collaborative Venture, *Journal of Nursing Management*, 15: 574-584.

Benner, P. (1984), *From Novice to Expert: Excellence and Power in Clinical Nursing Practice,* Addison-Wesley Publishing Company, California.

Benner, P., Hooper-Kyriakidis, P., Stannard, D. (1999), *Clinical Wisdom and Interventions in Critical Care: A Thinking in Action Approach,* Saunders, Philadelphia.

Benz, C., Newman, I. (1998), *Qualitative Research Methodology: Exploring the Interactive Continuum,* Carbondale: Southern Illinois University Press, Illinois.

Berg, B.L. (1998), *Qualitative Research Methods for the Social Sciences*, Allyn and Bacon, Boston.

Buresh, B., Gordon, S. (2000), *From Silence to Voice: What Nurses Know and Must Communicate to the Public,* ILR Press, Ithaca and London.

Campbell, M. (1987), Productivity in Canadian Nursing, *Colburn, D., D'Arcy, G., New, J. eds. Health in Canadian Society: Sociological Perspectives*. 2nd ed., McHenry & Whiteside, Toronto.

Carney, M. (1999), Leadership in Nursing: Where do we go from here? The Ward Sisters Challenge for the Future, *Nursing Review,* 17(1/2): 13-18.

Carney, M. (2004), Middle Manager Involvement in Strategy Development in not-for-profit organisations: the director of nursing perspective - how organisational structure impacts on the role, *Journal of Nursing Management,* 12: 13-21.

Castledine, G. (1996), Clarifying and Defining Nursing Role Developments. *British Journal of Nursing*, 5(21): 1338.

Castledine, G. (2003a), Generalist and Specialist Nurses - Complementary or Conflicting Roles? Unpublished.

Castledine, G. (2003b), Nurse Education and the NHS must integrate more, *British Journal of Nursing* 2003, 12(17): 1055.

Castledine, G. (2004), Basic Nursing Principles need to be remembered, *British Journal of Nursing* 2004, 13(6): 1055.

Central Statistics Office (CSO) (2004a), *Population and Labour Force Projections 2006-2036,* http://www.cso.ie/releasespublications/documents/population/2004/Publication%20Pop%20&%20Labour%20force%20for%20web.pdf (Accessed 14th August 2005).

Central Statistics Office (CSO) (2006), Census of the Population Statistics, www.cso.ie (Accessed 15th August 2007).

Central Statistics Office (CSO) (2007), *Principle Causes of Death 1998 – 2006,* www.cso.ie (Accessed 14th October 2007).

Chavasse, J. (2000), *Nursing Education,* In *Nursing and Midwifery in Ireland in the Twentieth Century* (Robins, J., Ed.), An Bord Altranais, 197-212, Dublin.

Community Midwifery Service, National Maternity Hospital (2001), *The National Maternity Hospital Domino and Hospital Outreach Home Birth Service: Pilot Project Evaluation,* Women's Health Unit, Northern Area Health Board, Dublin.

Condell, S. (1998), *Changes in the Professional Role of Nurses in Ireland: 1980 - 1997. A Report Prepared for the Commission on Nursing,* Stationery Office, Dublin.

Condon, D. (2004), How to attract staff and keep them, *The World of Irish Nursing*, 12: 19-20.

Council of European Communities (1980) *Council Directive (80/155/EEC) Concerning the Coordination of Provisions Laid down by Law, Regulation or Administrative Action Relating to the Taking up or Pursuit of the Activities of Midwives,* Council of European Communities, Brussels.

Creswell, J.W. (1998), *Qualitative Inquiry and Research Design: Choosing Among Five Traditions,* Sage Publications, London.

Crossan, F. (2003), Strategic Management and Nurses: Building Foundations, *Journal of Nursing Management,* 11: 331-335.

Department of Health (1965), *Report of the Commission of Enquiry on Mental Handicap,* Department of Health, Dublin.

Department of Health (1984), *The Psychiatric Services - Planning for the Future,* Stationery Office, Dublin.

Department of Health (1986), *Health: The Wider Dimensions. A Consultative Statement on Policy,* DoHC, Dublin.

Department of Health (1988), *The Years Ahead, A Policy for the Elderly,* Stationery Office, Dublin.

Department of Health (1989), *Report of the Commission on Health Funding*, Stationery Office, Dublin.

Department of Health (1989), *Working for Patients,* Cm 555, HMSO, London.

Department of Health (1991), *Reports (three) of the Dublin Hospital Initiative Group 1990-1991*, Stationery Office, Dublin.

Department of Health (1992), *Patients' Charter*, Stationery Office, Dublin.

Department of Health (1994), *Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s,* Stationery Office, Dublin.

Department of Health (1997a), *Statement of Strategy,* Department of Health, Dublin.

Department of Health (1997b), *A Plan for Women's Health 1997 to 1999,* Stationery Office, Dublin.

Department of Health (1997), *The New NHS: Modern, Dependable*, Department of Health, London.

Department of Health (1998), *A First Class Service: Quality in the New NHS*, Department of Health, Leeds.

Department of Health (1999), *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare,* HMSO, London.

Department of Health (2000), *The NHS Plan: A Plan for Investment, A Plan for Reform,* HMSO, London.

Department of Health (2006), *Modernising Nursing Careers - Setting the Direction*, HMSO, London.

Department of Health (1998a), *Strategy Statement 1998-2001: Working for Health and Wellbeing*, Department of Health and Children, Dublin.

Department of Health and Children (1998b), *Report of the National Task Force on Suicide,* Stationery Office, Dublin.

Department of Health and Children (1998c), Speech by the Minister for Health and Children, Mr. Brian Cowen TD, on the publication of the report of the

Commission on Nursing, 16th September 1998, Dublin Castle, Department of Health and Children, Dublin.

Department of Health and Children (1999a), *Children First - National Guidelines for the Protection and Welfare of Children,* Stationery Office, Dublin.

Department of Health and Children (1999b), *Building Healthier Hearts: The Report of the Cardiovascular Health Strategy Group,* Stationery Office, Dublin.

Department of Health and Children (1999c), *S.I. No. 376 of 1999, National Council for the Professional Development of Nursing and Midwifery (Establishment Order, 1999)*, Stationery Office, Dublin.

Department of Health and Children (2000a), *The National Health Promotion Strategy 2000-2005,* Stationery Office, Dublin.

Department of Health and Children (2000b), *Report of the Paediatric Nurse Education Review Group,* Nursing Policy Division, Department of Health and Children, Dublin.

Department of Health and Children (2001a), *Quality and Fairness: A Health System for You,* Stationery Office, Dublin.

Department of Health and Children (2001b), *Report of the National Advisory Committee on Palliative Care,* Stationery Office, Dublin.

Department of Health and Children (2001c), *Primary Care: A New Direction,* Stationery Office, Dublin.

Department of Health and Children (2001d), *Effective Utilisation of Professional Skills of Nurses and Midwives,* Department of Health and Children, Dublin.

Department of Health and Children (2002a), *The Health of our Children - Annual Report of the Chief Medical Officer,* Department of Health and Children, Dublin.

Department of Health and Children (2002b), *The Nursing and Midwifery Resource: Final Report of the Steering Group. Towards Workforce Planning,* Stationery Office, Dublin.

Department of Health and Children (2002c), *National Study of Turnover in Nursing and Midwifery*, Department of Health and Children, Dublin.

Department of Health and Children (2003a), *The Health Service Reform Programme,* Stationery Office, Dublin.

Department of Health and Children (2003b), *Audit of Structures and Functions in the Health System,* Stationery Office, Dublin.

Department of Health and Children (2003c), *Report of the National Task Force on Medical Staffing,* Department of Health and Children, Dublin.

Department of Health and Children (2003d), *Report of the National Task Force on Medical Staffing 2003: The Challenge for Nursing and Midwifery A Discussion Paper,* Department of Health and Children, Dublin.

Department of Health and Children (2003e), *Ireland's Changing Heart. Second Report on Implementation of the Cardiovascular Health Strategy,* Stationery Office, Dublin.

Department of Health and Children (2003f), *A Research Strategy for Nursing and Midwifery in Ireland - Final Report,* Stationery Office, Dublin.

Department of Health and Children (2003g), *Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland,* Nursing Policy Division, Department of Health and Children, Dublin.

Department of Health and Children (2003h), *Evaluation of the Irish Pilot Programme for the Education of the Healthcare Assistants*, Stationery Office, Dublin.

Department of Health and Children (2004), *Health Information – A National Strategy,* Stationery Office, Dublin.

Department of Health and Children (2005a), *Obesity The Policy Challenges: Report of the National Taskforce on Obesity,* Department of Health and Children, Dublin.

Department of Health and Children (2005b), *The Health Service Reform Programme Website* www.healthreform.ie (Accessed 15th January 2005), Department of Health and Children, Dublin.

Department of Health and Children (2005c), *SI No. 132 of 2005, Interim Health Information and Quality Authority (Establishment Order 2005)*, Stationery Office, Dublin.

Department of Health and Children (2006), *The Policy Role of the Department of Health and Children within the Irish Health Services*, National Council Annual Conference, 15th November 2006, Unpublished Speech.

Department of Health and Children (2007) *Health in Ireland – Key Trends 2007*, Department of Health and Children, Dublin.

Department of Health, Social Services and Public Safety (1998), *Valuing Diversity… A Way Forward – A Strategy for Nursing, Midwifery and Health Visiting – 1998*, DHSSPS, Belfast.

Department of Health, Social Services and Public Safety (2003), *Valuing Diversity… A Way Forward – A Strategy for Nursing, Midwifery and Health Visiting – 1998 – Summary of Achievements 1998 – 2003*, DHSSPS, Belfast.

Department of Health, Social Services and Public Safety (2004), *A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland*, DHSSPS, Belfast.

Department of Health, Social Services and Public Safety (DHSSPS) and Department of Health and Children (Department of Health and Children) (2001), *A Nursing Vision of Public Health – All Ireland Statement on Public Health and Nursing*, DHSSPS and Department of Health and Children, Belfast and Dublin.

Department of Health, Social Services and Public Safety (DHSSPS) and Department of Health and Children (DoHC) (2003), *From Vision to Action - Strengthening the Nursing Contribution to Public Health,* DHSSPS and Department of Health and Children, Belfast and Dublin.

Department of Health, Social Services and Public Safety (DHSSPS) and Department of Health and Children (DoHC) (2005), *Nursing for Public Health – Realising the Vision*, DHSSPS and Department of Health and Children, Belfast and Dublin.

Department of Health Western Australia (2003), *Guiding Framework for the Implementation of Nurse Practitioners in Western Australia,* DHWA, Perth, W.A.

Department of the Taoiseach (1996), *Delivering Better Government: Second Report to the Government of the Coordinating Group of Secretaries - A Programme of Change for the Irish Civil Service,* Stationery Office, Dublin.

Department of Tourism, Sport and Recreation (2001), *Building on Experience. National Drugs Strategy 2001-2008,* Stationery Office, Dublin.

Downs, F. (1999), *Readings in Research Methodology,* Lippincott Williams & Wilkins, Philadelphia.

Dublin Academic Teaching Hospitals (2000), *DATHs Nursing Recruitment & Retention Group Report 2000,* Dublin Academic Teaching Hospitals, Dublin.

Duffy, K., Ferguson, C., Watson, H. (2004), Data Collecting in Grounded Theory - Some Practical Issues, *Nurse Researcher,* 11 (4); 67-79.

Dunham, J. and Klafehn, K. (1990), Transformational Leadership and the Nurse Executive, *Journal of Nursing Administration* 20(4): 28-33.

Economic and Social Research Institute (2002), *Activity in Acute Public Hospitals in Ireland 1990-1999,* Economic and Social Research Institute, Dublin.

Economic and Social Research Institute (2003), *Bed Occupancy Rates in Irish Healthcare Institutions 2003,* Economic and Social Research Institute, Dublin.

European Ministers of Education (1999), *European Higher Education Area - Joint Declaration of the European Ministers of Education,* Convened in Bologna on the 19th of June 1999, http://www.dfes.gov.uk/londonbologna/ (Accessed 16th August 2007).

Fahey, T., Russell, H., Whelan, L.T. (2007), *Best of Times? The Social Impact of the Celtic Tiger*, Institute of Public Administration, Dublin.

FAS (2005), *Healthcare Skills Monitoring Report,* FAS, Dublin.

Flynn, M. (1998), *Management in the Health Services - The Role of the Nurse. A Report prepared for the Commission on Nursing,* Stationery Office, Dublin.

Fradd, L. (2004), Political Leadership in Action, *Journal of Nursing Management*, 12: 242-245.

Frechtling, J. & Westat, L.S. (1997), User Friendly Ed., *Handbook for Mixed Method Evaluations*, National Science Foundation Program Officer, Conrad Katzenmeyer, Directorate for Education and Human Resources. http://www.ehr.nsf.gov/ehr/rec/pubs/nsf97-153/start.htm#toc (Accessed 17th August 2007).

Friel, S., Nic Gabhainn, S. & Kelleher, C. (1999), *The National Health and Lifestyle Surveys: Survey of Lifestyle Attitudes and Nutrition (SLAN) and the Irish Health Behaviour in School Age Children (HBSC),* Centre for Health Promotion Studies, Galway.

Friese, S. (2004), *Software Overview*, Qualitative Research and Consulting, Bissendorf, Germany, http://www.quarc.de/software_overview_table.pdf (Accessed 17th August 2007).

George, J. (1996), *Nursing Theories: The Base for Professional Nursing Practice*, 4th Edition, Appleton and Lang, Norwalk CT.

Government of Ireland (1919), *The Nurses Registration Act 1919,* Stationery Office, Dublin.

Government of Ireland (1950), *Nurses Act, 1950,* Stationery Office, Dublin.

Government of Ireland (1961), *Nurses Act, 1961,* Stationery Office, Dublin.

Government of Ireland (1970), *Health Act, 1970,* Stationery Office, Dublin.

Government of Ireland (1980), *Report of the Working Party on General Nursing*, Stationery Office, Dublin.

Government of Ireland (1985), *Nurses Act, 1985,* Stationery 0ffice, Dublin.

Government of Ireland (1994), *Strategic Management Initiative*, Stationery Office, Dublin.

Government of Ireland (1997a), *No. 27/1977 Public Services Management Act 1997,* Stationery Office, Dublin.

Government of Ireland (1997b), *Freedom of Information Act 1997*, Stationery Office, Dublin.

Government of Ireland (1997c), *Commission on Nursing Interim Report*, Stationery Office, Dublin.

Government of Ireland (1998), *Report of the Commission on Nursing - A Blueprint for the Future,* Stationery Office, Dublin.

Government of Ireland (2000), *The National Children's Strategy. Our Children – Their Lives,* Stationery Office, Dublin.

Government of Ireland (2001), *Mental Health Act 2001*, Stationery Office, Dublin.

Government of Ireland (2003), *Report of Commission on Financial Management and Control Systems in the Health Service,* Stationery Office, Dublin.

Government of Ireland (2004), *Health Act, 2004,* Stationery Office, Dublin.

Government of Ireland (2006), *A Vision for Change – Report of the Expert Group on Mental Health Policy*, Stationery Office, Dublin.

Government of Ireland (2007a), *Measuring Ireland's Progress 2006*, Stationery Office, Dublin.

Government of Ireland (2007b), *Health Act 2007*, Stationery Office, Dublin.

Government of Ireland (2007c), *Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) Order 2007,* Stationery Office, Dublin.

Government of Ireland (2007d), *Misuse of Drugs (Amendment) Regulations 2007, Statutory Instruments No. 200 of 2007,* Stationery Office, Dublin.

Government of Ireland (2007e), *Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007, Statutory Instruments No. 201 of 2007,* Stationery Office, Dublin.

Great Britain (1990), *National Health Service and Community Care Act 1990: Elizabeth II. Chapter 19*, (1990) London: The Stationery Office.

Griffin, M. and Melby, V. (2006), Developing an Advanced Nurse Practitioner Service in Emergency Care: Attitudes of Doctors and Nurses, *Journal of Advanced Nursing*, 56(3): 292-301.

Griffiths, R. (1983), *NHS Management Inquiry (The Griffiths Report),* Department of Health and Social Security, London.

Hanafin, S. (1997), The Role of the Irish Public Health Nurse: manager, clinician and health promoter, *Health Visitor*, 70(8): 295-297.

Hanafin, S., Houston, A.M. and Cowley, S. (2002), Vertical Equity in Service Provision: A Model for the Irish Public Health Nursing Service, *Journal of Advanced Nursing,* 39(1): 68-76.

Hayes, K., Carroll, S. (2007), Cancer Specialist Condemns Diagnosis System, *Irish Times*, 8th August 2007.

Health Research Board (2002), *Making Knowledge Work for Health: A Strategy for Health Research,* Brunswick Press Ltd., Dublin.

Health Research Board (2004), *National Intellectual Disability Database: Annual Report of the National Intellectual Disability Committee 2004,* Health Research Board, Dublin.

Health Service Executive (2005), *Reach Out – A National Strategy for Action on Suicide Prevention*, HSE, Dublin.

Health Service Executive (2006a), *Leas Cross Review,* Health Service Executive, Dublin.

Health Service Executive (2006b), *Transformation Programme 2007-2010,* Health Service Executive, Dublin.

Health Service Executive (2006c), *Expert Advisory Groups*, Health Service Executive, Dublin.

Health Service Executive (2006d), Message from the CEO, *Health Service Executive Health Matters, Summer.* Health Service Executive, Dublin.

Health Service Executive (2006e), *A Strategy for Practice Development*, Health Service Executive South East Nursing and Midwifery Planning and Development Unit, Waterford.

Health Service Executive (2007a), HSE Transformation Programme and PCCC Programme, *Health Service Executive Health Matters*, Summer, Health Service Executive, Dublin.

Health Service Executive (2007b), *The Introduction of Nurse and Midwife Prescribing in Ireland: An Overview*, Health Service Executive, Dublin.

Health Service Executive (2007c), *A Literature Review of Post-Registration Nursing and Midwifery Education: An Interim Report*, Unpublished, Health Service Executive, Dublin

Health Service Executive (2007d), *A Literature Review of Post-Registration Nursing and Midwifery Education: A Report Commissioned by the Post-Registration and Post Graduate Nursing and Midwifery Education Review Group,* Unpublished, Health Service Executive, Dublin

Health Service Executive (2007e), *eLearning Guru*, http://www.elearningguru.com/ (Accessed 17th August 2007).

Health Service Executive (2007f), *Nursing and Midwifery Turnover Data Report for Year Ending 2005 For HSE Areas of Counties Dublin, Kildare and Wicklow*, HSE Nursing and Midwifery Planning and Development Unit for the Counties of Dublin, Kildare and Wicklow, Health Service Executive, Dublin.

Health Service Executive (2007g), A Time of Unlimited Opportunity for Nursing and Midwifery, *Health Service Executive Health Matters,* Autumn, Health Service Executive, Dublin.

Health Service Executive Employers Agency (2007), New Deadline for Implementation of the European Working Time Directive for NCHDs, *Health Service Executive Employers Agency Newsletter*, Summer, Health Service Executive, Dublin.

Henderson, V. (1961), *Basic Principles of Nursing Care*, International Council of Nurses, London.

Henderson, V. (1966), *The Nature of Nursing: A Definition and its Implications, Practice, Research, and Education*, Macmillan Company, New York.

Hennessy, D.A., Rowland, H. & Buckton, K. (1993), The Corporate Role of the Nursing Director, *Journal of Nursing Management,* 1: 161-169.

Hennessy, D.A., Gilligan, J.H. (1994), Identifying and Developing Tomorrows Trust Nursing Directors, *Journal of Nursing Management*, 2: 37-45.

Hofman, H. (2007a), Bringing Care Back Home, *Irish Times Health Supplement*, 17th July 2007.

Hofman, H. (2007b), Shared Online Patient Files are Saving Time, Money, *Irish Times Health Supplement*, 10th April 2007.

Houston, M. (2007), Two Major Dublin Hospitals Join Forces, *Irish Times Health Supplement,* 7th August 2007.

Ingle, R. (2007), There is now a real concern for patient safety. We need more doctors, more midwives, more nurses. *Irish Times Weekend Review*, 22nd September 2007.

Interim Health Information and Quality Authority (2007), Interim Health Information and Quality Authority to Play Supporting Role in New Commission on Patient Safety and Quality Assurance, *Interim Health Information and Quality Authority News Update, March*.

International Confederation of Midwives / World Health Organisation / International Federation of Gynaecologists and Obstetricians (1992), *The definition of a midwife was adopted by the International Confederation of Midwives (ICM), International Federation of Gynaecologists and Obstetricians (FIGO), in 1972 and 1973 respectively and later adopted by the World Health Organisation (WHO). This definition was amended by the ICM in 1990 and the amendment ratified by the FIGO and the WHO in 1991 and 1992 respectively.*

Irvine, D., Leatt, P., Evans, M. and Baker, R. (1999), Measurement of Staff Empowerment within health service organisations, *Journal of Nursing Measurement,* 7(1): 79-95.

Janesick, V.J. (2003), The Choreography of Qualitative Research Design: Minuets, Improvisation and Crystallization, *Denzin, N.K. & Lincoln, Y. Eds., Strategies of Qualitative Inquiry,* 2nd Ed., Sage, London.

Johnson, R.B. (1997), Examining the Validity Structure of Qualitative Research, *Education,* 118(2): 282-290.

Jones, M.L. (2005), Role Development and Effective Practice in Specialist and Advanced Practice Roles in Acute Hospital Settings: Systematic Review and Meta-Synthesis, *Journal of Advanced Nursing*, 49(2): 191-209.

Kanter, R.M. (1993), *Men and Women of the Corporation,* Basic Books, New York.

Kelleher, A. and Musgrave, E. (2000), Sick Children's Nursing, *Nursing and Midwifery in Ireland in the Twentieth Century* (Robins, J., ed.) An Bord Altranais, 177-196, Dublin.

Kelleher, C., Nic Gabhainn, S., Friel, S., Corrigan, H., Nolan, G., Sixsmith, J., Walsh, O. & Cooke, M. (2003), *The National Health and Lifestyle Surveys: Survey of Lifestyle Attitudes and Nutrition (SLAN) and the Irish Health Behaviour in School Age Children (HBSC),* Centre for Health Promotion Studies, Galway.

King's Fund (1996), *Leadership Programme*, King's Fund, London.

King's Fund (2006), *Grow Your Own - Creating the Conditions for Sustainable Workforce Development*, King's Fund, London.

Kitson, A. (1999), The Essence of Nursing, *Nursing Standard*, 13(23):42-46.

Klakovich, M (1995), Development and Psychometric Evaluation of the Reciprocal Empowerment Scale, *Journal of Nursing Measurement,* 3(2):127-143.

Labour Court (1997), Recommendation No. LRC 15450, CD/97/48.

Laing, R.D. (1971), *The Politics of the Family and Other Essays*, Pantheon, New York.

Laschinger, H.K.S., Wong, C., McMahon, L., Kaufmann, C. (1999), Leader Behaviour Impact on Staff Nurse Empowerment, Job Tension and Work Effectiveness, *Journal of Nursing Administration,* 29(5): 28-39.

Laschinger, H.K.S., Finegan, J., Shamian, J., Wilk, P. (2001a), Impact of Structural and Psychological Empowerment on Job Strain in Nursing Work Settings, *Journal of Nursing Administration* 31(5): 260-272.

Laschinger, H.K.S., Finegan, J., Shamian, J. and Casier, S. (2001b), Organisational Trust and Empowerment in Restructured Healthcare Settings, *Journal of Nursing Administration,* 30(9): 413-425.

Lavin, M.A., Ruebling, I., Banks,R., Block, L., Counte, M., Furman, G., Miller, P., Reese, C., Viehmann, V. and Holt, J. (2001), Interdisciplinary Professional Education: A Historical Review, *Advances in Health Science Education*, 6: 25-47.

Leahy-Warren, P. (1998), *Community Nursing - An International Perspective. A Report prepared for the Commission on Nursing,* Stationery Office, Dublin.

Leahy-Warren, P., Tyrrell, M.P. (1998), *Joint Appointments in Nursing. A Report prepared for the Commission on Nursing,* Stationery Office, Dublin.

Lincoln, Y.S., Guba, E.G. (1985), *Naturalistic Inquiry*, Sage Publications, Newbury Park.

Lincoln, Y.S., Guba, E.G. (2003), Paradigmatic Controversies, Contradictions and Emerging Confluences, *Denzin, N.K. & Lincoln, Y. Eds., The Landscape of Qualitative Research: Theories and Issues,* 2nd Ed., Sage, London.

Locke, K. (2001), *Grounded Theory in Management Research,* Sage Publications, London.

Mac Lellan, K. (2007), Expanding Practice: Developments in Nursing and Career Pathways, *Nursing Management*, 14(3): 28-34.

Marsden, J., Dolan, B., Holt, L. (2003), Nurse Practitioner Practice and Deployment: Electronic Mail Delphi Study, *Journal of Advanced Nursing*, 43(6): 595-605.

Mason, J. (1996), *Qualitative Researching*, Sage Publications, London.

Mathers, Nigel; Fox, Nick and Hunn, Amanda (1998), *Trent Focus for Research and Development in Primary Health Care: Using Interviews in a Research Project,* Trent Focus, Trent.

Maxwell, J.A. (1992), Understanding and Validity in Qualitative Research, *Harvard Education Review,* 62(3): 279-300.

McKenna, H.P., Keeney, S and Bradley, M. (2004), Nurse Leadership within Primary Care: The Perceptions of community Nurses, GPs, Policy Makers and Members of the Public, *Journal of Nursing Management*, 12: 169-76.

Medel-Anonuevo, C., Ohsako, T., Mauch, V. (2001), *Revisiting Lifelong Learning in 21st Century*, UNESCO Institute for Education.

Mid-Western Health Board, Nursing and Midwifery Planning and Development Unit, Mid-Western Region (2003), *An Explorative Study into the Expansion of Nursing and Midwifery Professional Roles in Response to the European Working Time Directive,* Mid-Western Health Board, Limerick.

Miles, M.B., Huberman, A.M. (1994), *Qualitative Data Analysis: An Expanded Sourcebook,* Sage Publications, London.

Ministry of Public Works and Government (2003), *A Report on the Nursing Strategy for Canada,* Health Canada, Ottawa, Ontario.

Myers, M. (2000), Qualitative Research and the Generalisability Question: Standing Firm with Proteus, *The Qualitative Report,* 4(3/4): 34-41.

National Assembly for Wales (1999), *Realising the Potential: A Strategic Framework for Nursing, Midwifery and Health Visiting in Wales into the 21st Century*, National Assembly for Wales, Cardiff.

National Council for the Professional Development of Nursing and Midwifery (2001a), *Clinical Nurse / Midwife Specialists Intermediate Pathway,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2001b), *Framework for the establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2001c), *Criteria and Processes for the Allocation of Additional Funding for Continuing Education by the National Council,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2002), *Guidelines on the Development of Courses Preparing Nurses and Midwives as Clinical Nurse / Midwife Specialists and Advanced Nurse / Midwife Practitioners,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2003a), *Agenda for the Future Professional Development of Nursing and Midwifery,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2003b), *Guidelines for Portfolio Development for Nurses and Midwives,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2003c), *Guidelines for Health Service Providers for the Selection of Nurses and Midwives who might apply for financial support in seeking opportunities to pursue further education,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2004a), *Framework for the Establishment of Clinical Nurse / Midwife Specialist Posts Intermediate Pathway - 2nd Edition,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2004b), *Framework for the establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts - 2nd Edition,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2004c), *An Evaluation of the Effectiveness of the Role of Clinical Nurse/Midwife Specialist in Ireland,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2004d), *Report on the Continuing Professional Development of Staff Nurses and Midwives,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2005a), *Agenda for the Future Professional Development of Public Health*

Nursing, National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2005b), *Clinical Nurse Specialists and Advanced Nurse Practitioner Roles in Emergency Departments: Position Paper,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2005c), *Service Needs Analysis for Clinical Nurse / Midwife Specialists and Advanced Nurse / Midwife Practitioners,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2005d), *A Study to Identify Research Priorities for Nursing and Midwifery in Ireland,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2005e), *A Preliminary Evaluation of the Role of the Advanced Nurse Practitioner*, National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2005f), *An Evaluation of the extent and nature of nurse-led / midwife led services in Ireland,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2005g), *The Development of Joint Appointments: A Framework for Irish Nursing and Midwifery,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2006a), *Review of Achievements 2001 to 2006,* National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2006b), *Clinical Nurse Specialist and Advanced Nurse Practitioner Roles in Intellectual Disability Nursing: Position Paper 2*, National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2006c), *Report on the Baseline Survey of Research Activity in Irish Nursing and Midwifery*, National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2006d), *Guidelines for Portfolio Development for Nurses and Midwives,* 2nd Ed., National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2006e), *Measurement of Nursing and Midwifery Interventions: Guidance and Resource Pack*, National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2006f), *Improving the Patient Journey - Understanding Integrated Care Pathways*, National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2007a), CNS/CMS and ANP/AMP Statistics, http://www.ncnm.ie (Accessed 13th September 2007).

National Council for the Professional Development of Nursing and Midwifery (2007b) *Framework for the Establishment of Clinical Nurse Specialist and Clinical Midwife Specialist Posts*, 3rd Edition, National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2007c) *Framework for the Establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts*, 3rd Edition, National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2007d) *Clinical Nurse Specialist and Advanced Nurse Practitioner Roles in Older Persons Nursing: Position Paper 3*, National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2007e), *Criteria and Processes for the Allocation of Additional Funding for Continuing Education by the National Council,* 2nd Edition, National Council for the Professional Development of Nursing and Midwifery, Dublin.

Nelson Haggemaster, J. (1992), Life History: A Qualitative Method of Research, *Journal of Advanced Nursing*, 17: 1122-1128.

Neuman, B. (1995), *The Neuman Systems Model*, 3rd Edition. Appleton and Lang, Norwalk CT.

Nightingale, F. (1860), *Notes on Nursing – What it is, and what it is not.* D. Appleton and Company, New York.

North Eastern Health Board (NEHB) (2001), *Report of the Maternity Services Review Group,* North Eastern Health Board, Drogheda.

Nursing Council of New Zealand (2001), *The Nurse Practitioner*, Nursing Council of New Zealand, Wellington.

O'Brien, P. (2007), Value-for-money Review is Futile and Flawed, *The Irish Times Health Supplement*, 14th August, 2007.

Office for Public Management (2001), *The Joint Appointments Guide: A Guide to Setting Up, Managing and Maintaining Joint Appointments for Health Improvements between Health Organisations and Local Government*, OPM, London.

Office for Health Management (OHM) (1998), *Clinicians in Management – The Next Steps: Facilitating Management Development for the Health Services. A Report on a One Day Conference in Dublin Castle Launching a New Initiative to Promote Clinicians in Management*, Office for Health Management, Dublin.

Office for Health Management (OHM) (2000), *Report on Nursing Management Competencies,* Office for Health Management, Dublin.

Office for Health Management (OHM) (2003a), *Learning from the NHS in Change – A Study on the Management of Major Structural Change in the NHS*, Office for Health Management, Dublin.

Office for Health Management (OHM) (2003b), *Report on an Evaluation Study of the Leading an Empowered Organisation Programme (LEO) for Clinical Nurse Managers 1*, Office for Health Management, Dublin.

Office for Health Management (OHM) (2003c), *Report on the Diagnostic Exercise for Directors of Nursing/Equivalent Nursing Management Grades,* Office for Health Management, Dublin.

Office for Health Management (OHM) (2003d), *Clinicians in Management: Charter of Rights and Responsibilities of Consultants, Clinical Directors and Senior Hospital Managers within the Acute Hospital Setting*, Office for Health Management, Dublin.

Office for Health Management (OHM) (2004a), *The Management Competency User Pack for Nurse and Midwife Managers*, Office for Health Management, Dublin.

Office for Health Management (OHM) (2004b), *Leadership Development Programme Past Participants - Where are they Now?* Office for Health Management Newsletter, Issue 5, Dublin.

O'Hara, T. (1998), Current Structure of the Irish Healthcare System – Setting the Context, *Leahy, A.L. & Wiley, M.M. (1998), The Irish Health System in the 21st Century*, Oak Tree Press, Dublin.

Orb, A., Eisenhauer, L., Wynaden, D. (2001), Ethics in Qualitative Research, *Journal of Nursing Scholarship*, First Quarter, 93-96.

Orem, D.E. (1985), *Nursing: Concepts of Practice*, 3rd Edition, McGraw Hill, New York.

Organisation for Economic Cooperation and Development (OECD) (2007), *Health Data 2007: Statistics and Indicators for 30 Countries*, OECD, Paris, http://www.oecd.org/health/healthdata (Accessed 13th August 2007).

O'Shea, Y. (1995) *Resource Management and the Clinical Directorate Model: Implications for St. James's Hospital, Dublin*, University of Dublin, Trinity College, Unpublished MSc Econ. Dissertation, Dublin.

PA Knowledge Ltd. (2007), *Acute Hospital Bed Review: A Review of Acute Hospital Bed Use in Hospitals in the Republic of Ireland with an Emergency Department*, PA Consulting Group, London.

Pan Canadian Steering Committee (2005), *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada - Phase I Final Report*, www.buildingthefuture.ca (Accessed 15th August 2006).

Qualis Research Associates (2001), *Ethnographv5.08 - eManual,* Qualis Research Associates, London.

Richardson, L. (1994), Writing: A Method of Inquiry, *N.K. Denzin & Y.S. Lincoln (Eds.) Handbook of Qualitative Research:* 516-529, Thousand Oaks, Sage, California.

Robins, J. (2000), *Bord Altranais 1950-1970,* In *Nursing and Midwifery in Ireland in the Twentieth Century* (Robins, J., ed.), An Bord Altranais, 29-49, Dublin.

Robson, C. (2002), *Real World Research - A Resource for Social Scientists and Practitioner-Researchers,* Blackwell Publishing, London.

Roper, N., Logan, W.W., Tierney, A.J. (2000), *The Roper-Logan-Tierney Model of Nursing: Based on Activities of Living*, Elsevier Health Sciences, Edinburgh.

Rogers, C. (1976), *Introduction to Nursing – An Adaptation Model*, Prentice Hall, New York.

Savage, E.B. (1998), *An Examination of the Changes in the Professional Role of the Nurse Outside Ireland: 1980 - 19997. A Report Prepared for the Commission on Nursing,* Stationery Office, Dublin.

Scoble, K., Russell, G. (2003), Vision 2020, Part 1: Profile of the Future Nurse Leader, *Journal of Nursing Administration,* 33(6): 324-330,

Scott, P.A., Hayes, E. & MacNeela, P. (2006), *An Exploration of the Core Nursing Elements of Care Provided by Registered General Nurses within the Community Setting*, Dublin City University, Dublin.

Scottish Executive Health Department (2001), *Caring for Scotland: The Strategy for Nursing and Midwifery in Scotland*, Scottish Executive, Edinburgh.

Sheridan, A. (2000), Psychiatric Nursing, *Nursing and Midwifery in Ireland in the Twentieth Century* (Robins, J., ed.), An Bord Altranais, 141-161, Dublin.

Singleton, Jr., R.A., Straits, B.C. (1999), *Approaches to Social Research*, Oxford University Press, New York.

SKILL Project, www.skillproject.ie (Accessed 14th October, 2007)

Sofarelli, D., Brown, D. (1998), The Need for Nursing Leadership in Uncertain Times, *Journal of Nursing Management,* 6(4): 201-207.

South West Thames Regional Authority (1992), *A Competency Framework for Trust Nursing Directors,* South West Thames Regional Health Authority, London.

St. James's Hospital (1996), *Tender for Establishment and Provision of Cardiac Surgery Services at St. James's Hospital,* St. James's Hospital, Dublin.

Stake, R.E. (2003), Case Studies, *Denzin, N.K., Lincoln, Y. Eds., Strategies of Qualitative Inquiry,* 2nd Ed., Sage, London.

Storey, L. (2001), *The Concept of Competence*, Assessment of Competence Conference Proceedings, An Bord Altranais, Dublin.

Surridge, H. (2007), *Qualitative Research and Critical Appraisal*, Southampton, North West Hampshire Research and Development Support Unit, 18th January 2007, Southampton General Hospital, http://www.rdsu.soton.ac.uk (Accessed 16th August 2007).

Taylor, C. (2005), *What Packages are available?*, School of Human and Health Sciences, University of Huddersfield, England, http://onlineqda.hud.ac.uk/which_software/what_packages_are_available/, (Accessed 17th August 2007).

Taylor, C. (2006), *Online QDA*, School of Human and Health Sciences, University of Huddersfield, England, http://onlineqda.hud.ac.uk/glossary.php#s (Accessed 17th August 2007).

Teamwork Management Services Ltd. (2006), Health Service Executive: Improving Safety and Achieving Better Standards - An Action Plan for Health Service in the North East, Teamwork Services Management Ltd., Bolton.

Technology Informatics Guiding Education Reform (TIGER) (2007), *The TIGER Initiative - Evidence and Informatics Transforming Nursing: 3 Year Action Steps towards a 10 Year Vision,* www.tigersummit.com (Accessed 12th March 2005).

Titchen, A. (1998), *Professional Craft Knowledge in Patient-Centred Nursing and the Facilitation of its Development*, Unpublished D.Phil Thesis, Department of Education Studies, University of Oxford.

Treacy, M.P., Hyde, A. (2003), Developments in Nursing in Ireland: The Emergence of a Disciplinary Discourse, *Journal of Professional Nursing,* 19(2): 91-98.

Tutty, L.M., Rothery, M., Grinnell, Jr., R.M. (1996), *Qualitative Research for Social Workers*, Allyn and Bacon, Boston.

Tyrrell, M.P. (1998), *Developments in Pre-Registration Nursing Education - An International Perspective. A Report prepared for the Commission on Nursing,* Stationery Office, Dublin.

University College Dublin (2007), Information on Post of Professor of Clinical Nursing (Acute Care Nursing) and Professor of Clinical Nursing (Palliative Nursing), https://www.ucd.ie (Accessed 13th September 2007).

Upenieks, V. (2003), Nurse Leaders' Perceptions of What Comprises Successful Leadership in today's Acute Inpatient Environment, *Nursing Administration Quarterly,* 27(2): ProQuest Nursing Journals, 140-152.

Wall, M. (2006), New Body to Monitor Health Spending, *Irish Times Health Supplement*, 19th September 2006.

Wall, M. (2007a), Drumm Expands Plans for North East Services, *Irish Times Health Supplement,* 31st July 2007.

Wall, M. (2007b), HSE Seeks €500 million Savings in New Plan, Irish Times Health Supplement, 20th March 2007.

Wall, M. (2007c), State to Review Value of Nursing Degree, *Irish Times Health Supplement,* 31st July 2007.

Weitzman, E., Miles, M.B. (1995), *Computer Programmes for Qualitative Data Analysis: A Software Source Book*, University of Massachusetts, Boston.

West, E., Barron, D.N., Dowsett, J., Newton, J.N. (1999), Hierarchies and Cliques in the Social Networks of Healthcare Professionals: Implications for the Design of Dissemination Strategies, *Social Science and Medicine*, 48: 633-646.

West, E., Rafferty, A.M. (2004), *The Future Nurse: Evidence of the Impact of Registered Nurses,* University of York, York.

WHO (1981), *Global strategy for health for all by the year 2000*, WHO, Geneva.

WHO (1988), *Learning Together to Work Together for Health*, WHO, Geneva.

WHO (1993), *Nursing in Action – Strengthening Nursing and Midwifery to Support Health for All*, WHO Regional Office, Copenhagen.

WHO (1994), *Nursing Beyond the year 2000: Report of a WHO Study Group*, WHO, Geneva.

WHO (1996), *Nursing Practice – Report of a WHO Expert Committee*, WHO, Geneva.

WHO (1997), *A Strategy for Nursing and Midwifery Development in the Eastern Mediterranean Region*, WHO Regional Office for the Eastern Mediterranean, Alexandria.

WHO (1999), *Nurses and Midwives for Health: A WHO European Strategy for Nursing and Midwifery Education*, WHO Regional Office, Copenhagen.

WHO (2001), *The Ideal Attributes of Chief Nurses in Europe: A Delphi Study for WHO Europe,* WHO Regional Office, Copenhagen.

WHO (2002), *Nursing Midwifery Services: Strategic Directions 2002 – 2008*, WHO, Geneva.

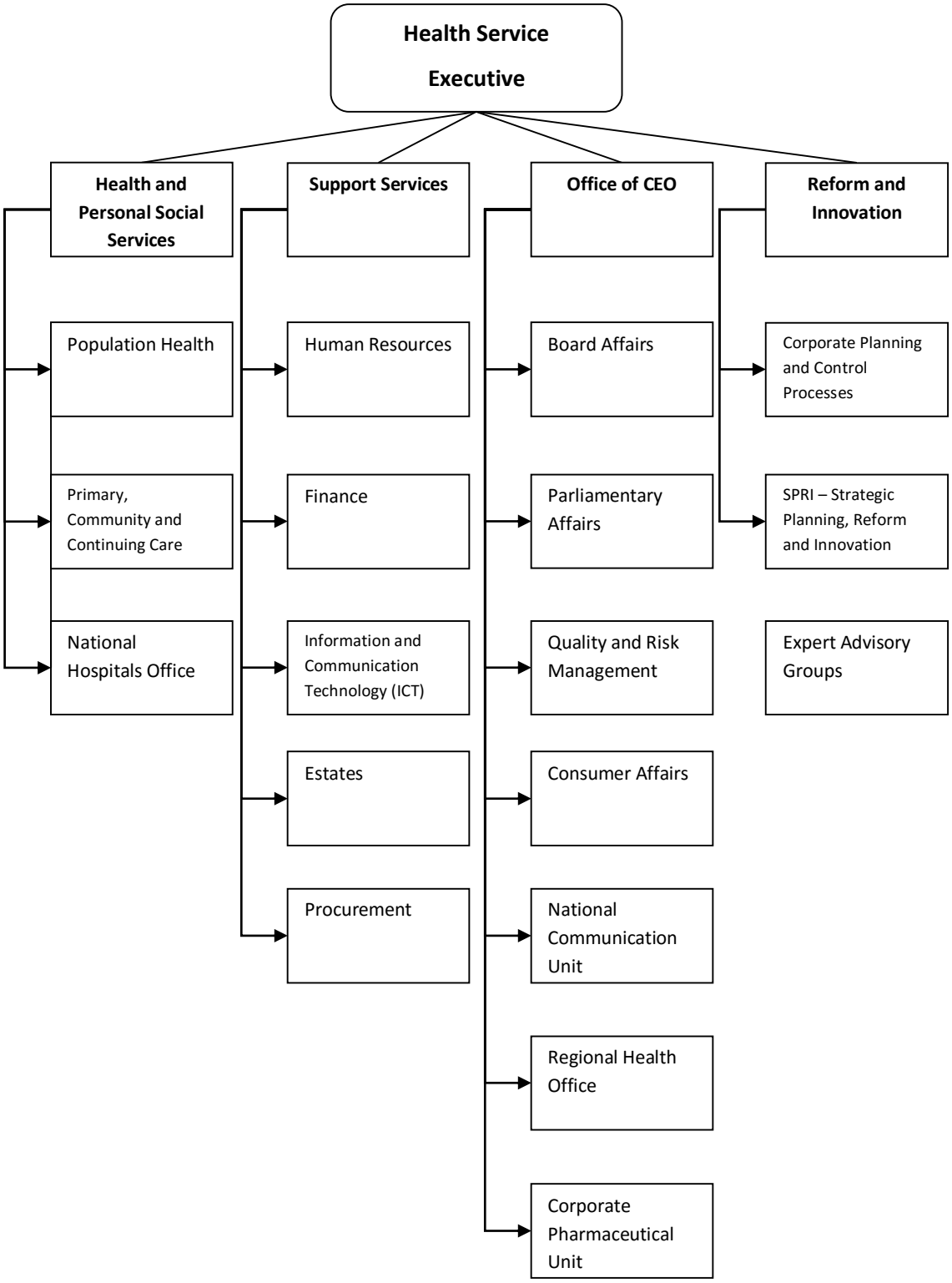
WHO (2003), *National Strategy and Plan of Action for Nursing and Midwifery Development in Iraq 2003 – 2008*, WHO Eastern Mediterranean Regional Office, Alexandria.

WHO (2004), *Health for All Database,* WHO Regional Office, Copenhagen.

Zwarenstein, M., Atkins, J., Barr, H., Hammick, M., Koppel, I. and Reeves, S. (1999), A Systematic Review of Interprofessional Education, *Journal of Interprofessional Care*, 13(4): 417-424.

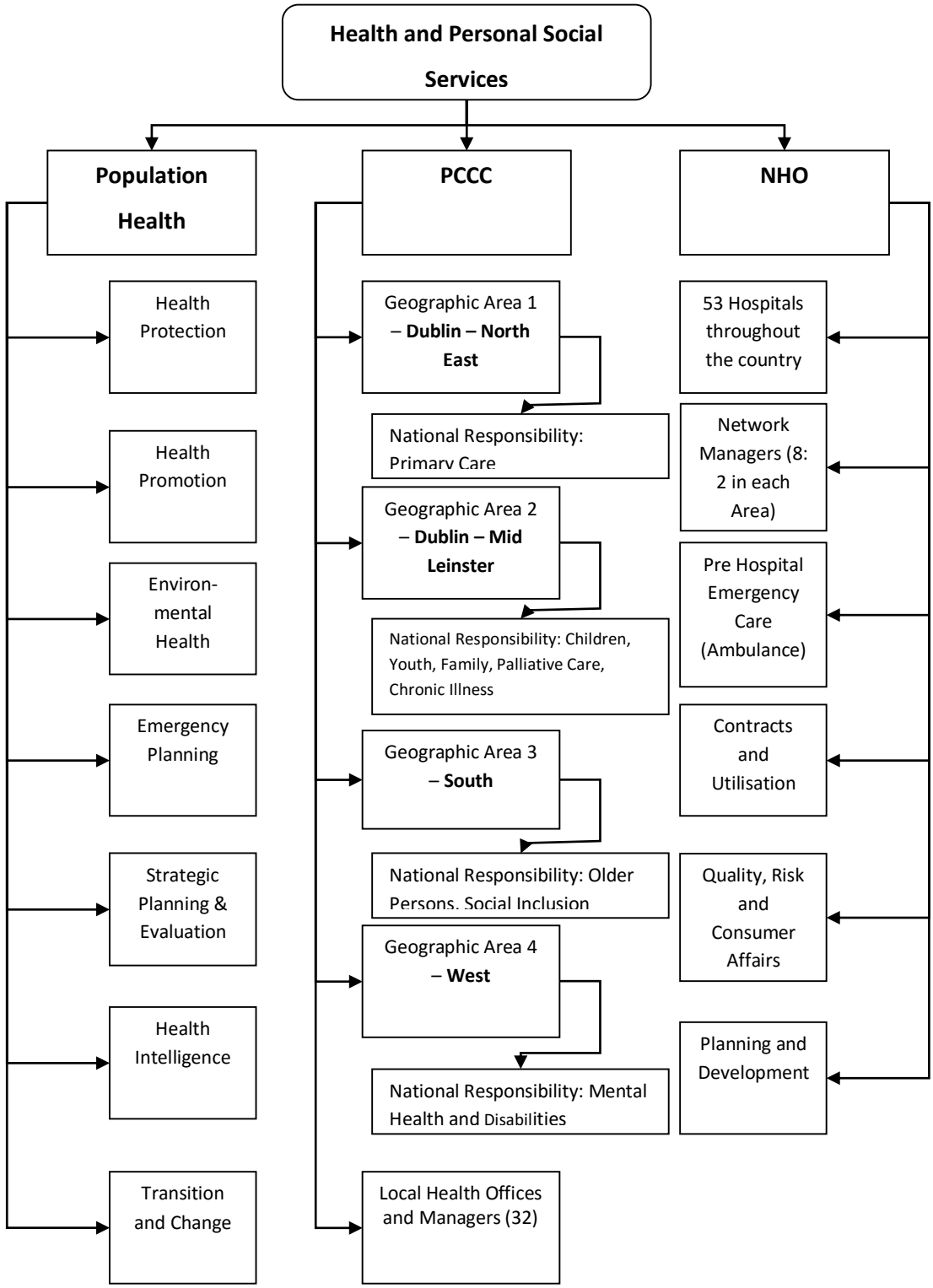
Appendices

Appendix 1 – HSE Institutional Map of Functions[56]



[56] This chart has been developed based on information contained on the website of the HSE http://www.hse.ie/en/AbouttheHSE/OurStructure/ (accessed in September 2007).

Appendix 2 – Health and Social Personal Services – Institutional Map of Functions[57]



[57] This chart has been developed based on information contained on the website of the HSE http://www.hse.ie/en/AbouttheHSE/OurStructure/ (accessed in September 2007).

Appendix 3 – Commission on Nursing – Summary of Progress

1. Regulation of the Profession –

- The recommendations in Chapter 4 – Regulation of the Profession are being addressed in the context of the Nurses (Amendment) Bill 2007
- The Healthcare assistants Programme was rolled out in 2003.

2. Preparation for the Profession –

- Nursing degree in General, Psychiatric and Intellectual Disability Nursing was introduced in 2002
- 18 Centres for Nurse Education have been established.
- The Nursing career Centre was established to promote nursing as a career.
- 40 sponsorships for mature student applications available annually.

3. Professional Development –

- The National Council for the Professional Development of Nursing and Midwifery was established in 1999.
- Clinical career pathway framework of generalist, specialist and advanced practice has been established
- Frameworks for the establishment of Clinical Nurse / Midwife Specialist posts and Advanced Nurse / Midwife Practitioner posts
- Roles including core concepts have been defined
- Eight Nursing and Midwifery Planning and Development Units (NMPDUs) have been established.
- Part of the role of the NMPDU includes overseeing the provision of continuing nursing and midwifery education for a health area.
- Joint appointment between Health Research Board and National Council established for the promotion of research within nursing.
- Nursing Research Strategy published in 2003 and research committee established.

4. The Role of Nurses and Midwives in the Management of Services –

- A Chief Nursing Officer was appointed in 1998 to the DoHC.
- The role of the Chief Nursing Officer includes playing a crucial role in the central planning and strategic development of nursing and midwifery and strengthening the workforce planning, professional leadership and quality assurance functions in the DoHC.
- *The Nursing and Midwifery Resource: Final Report of the Steering Group Towards Workforce Planning* was published in 2002.
- Two supporting texts relating to the study: *Guidance for Best Practice on the Recruitment of Overseas Nurses and Midwives* was published in December 2001, and *The Report of the National Study of Turnover in Nursing and Midwifery* was published in 2002.
- Nursing and Midwifery planning and Development Units (NMPDU) established in each health area, with a strategic planning and policy development role. It was intended that the Directors of NMPDUs should operate at a strategic planning level.
- The Commission defined the role of senior nursing and midwifery management as being to provide strategic and clinical leadership and direction for nursing and midwifery and related services. In order to emphasise this role, the title of all Matrons in large acute hospitals and Chief Nursing Officers in psychiatric services was changed to Director of Nursing.
- Matrons of smaller hospitals (bands 3, 4 and 5) were to combine a professional development role with detailed management responsibilities and should be given more explicit involvement in the determination of the budget and greater control and responsibility over its utilisation. The implementation of this recommendation varies throughout the country.
- The Commission recommended that middle nursing and midwifery management should have a defined management role and not merely a 'gatekeeping' administrative function. The implementation of this recommendation varies throughout the country.
- The Commission recommended that first line nursing and midwifery management should fulfil the following functions: professional

clinical leadership; staffing and staff development; resource management; facilitating communication. Management skills training was to be given. In recognition of these roles and of the differences in institutional settings in which first line nursing and midwifery management works, a new grading structure and title changes have been introduced: - Clinical Nurse Manager 1 or clinical Midwife Manager 1 (reporting to a clinical Nurse or Midwife Manager 2); Clinical Nurse Manager 2 or Clinical Midwife Manager 2 (in charge of a ward or unit area)**;** Clinical Nurse Manager 3 or Clinical Midwife Manager 3 (in charge of a department)

5. Nursing in the Community –

- National Strategy for Nursing and Midwifery in the Community (NAMIC) – Steering Group overseeing the development of the strategy met on thirteen occasions between November 2001 and October 2003. A final draft which included template and action plan was discussed. The report has not been published.
- In 2004, the requirement for midwifery qualification for entry to the Public Health Nurse Diploma was removed and substituted by a module in maternity and child care.
- The title Superintendent Public Health Nurse has been changed to Director of Public Health Nursing; the title Senior Public Health Nurse has been changed to Assistant Director Public Health Nursing.
- Registered general nurses as part of the community nursing team are in place, with on going developments.
- To enhance the delivery of intellectual disability nursing services – 23 Community Intellectual Disability Clinical Nurse Specialists are in place with more in development.
- To ensure an enhanced community mental health nursing service - 252 Community Mental Health Clinical Nurse Specialists and 1 Advanced Nurse Practitioner are in place with more in development.
- Practice Nurse coordinators have been established in each health area and are attached to the NMPDU, to assist in supporting the development needs of practice nurses.

6. Nursing in Care of the Elderly –

- Nurse Advisor/Palliative Care post was established in DoHC in 2002.
- Regional Practice Development coordinators in care of older persons are attached to the NMPDU, responsible for the development of guidelines and policies for acute, community and nursing homes.
- 46 Clinical Nurse Specialists and 1 Advanced Nurse Practitioner in Care of Older Person have been established.
- Centres of Nurse Education have completed a needs analysis of training needs for nurses working in care of the older person. Short education programmes are in place.

7. Midwifery –

- A direct entry degree programme in Midwifery commenced in 2006.

8. Children's Nursing –

- In 2004 the title Sick Children's Nurse was replaced with the title Registered Children's Nurse (RCN)**.**
- A direct entry degree programme in Registered Children's Nursing / General Nursing commenced in 2006.

Appendix 4 – Extract from a Speech by Minister for Health and Children, Mr. Brian Cowen, at the launch of the Report of the Commission on Nursing

Extract from a speech by the Minister for Health and Children, Mr. Brian Cowen, on the publication of the Report of the Commission on Nursing at Dublin Castle on the 16th September 1998 (DoHC, 1998):

> *As the Commission's Report says, the nursing profession is a cornerstone of the health services. I therefore view the publication of this report as a very significant event in terms of the 31,000 nurses who work within the public health service and for the future of the health services. I am also very aware that there had been a vacuum in the area of nursing over the last number of years, and that the absence of a major review of nursing in itself contributed to the feeling that nursing needed to move in a particular direction but that this direction had not been fully mapped out. This report being published today fills that void, and allows us to chart a steady course for the future development of nursing and midwifery within the health services. The aim of the 'Report of the Commission on Nursing, A Blueprint for the Future', is to develop the profession of nursing. Its recommendations are designed to free the profession from controls, practices and attitudes that have held nursing and midwifery in check, and which have prevented it achieving its full potential in the health services and in society.*

Appendix 5 – Policy Initiatives, Reports and Publications of the National Council – 2001 to 2006

Year / Initiative / Report / Publication	Summary
2001	
Criteria and Process for the allocation of additional funding for continuing education (February)	This document outlines the criteria and processes involved in the allocation of additional funding for continuing professional development and education for nurses and midwives
Clinical Nurse / Midwife Specialists – Intermediate Pathway (April)	This document outlines the process for establishment of CNS/CMS posts and the criteria that nurses and midwives must meet in order to become CNSs/CMSs.
Framework for the establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts (May)	This document provides a definition of the role of ANP / AMP and defines the criteria that nurses and midwives must meet to in order to become ANPs/AMPs.
National Council Newsletter, Issue 1 to 4	The newsletter of the National Council was introduced in 2001 and was intended as a platform for the dissemination of information and analysis of issues of relevance to nurses and midwives in Ireland.
2002	
Guidelines on the Development of Courses Preparing Nurses and Midwives as Clinical Nurse / Midwife Specialists and Advanced Nurse / Midwife Practitioners (May)	This document was produced to assist providers of continuing / post-registration education programmes for CNS / CMS and for ANP / AMPs. It provides guidelines in relation to development, design and evaluation of programmes.
National Council Newsletter, Issues 5 to 8	The Newsletter continued to provide information on developments of relevance to nursing and midwifery in Ireland. In this year a detailed series of analyses on the implications of the Health Service Reform Programme was introduced aimed at familiarising nurses and midwives with the details and implications of the reform programme
2003	
Agenda for the Future Professional Development of Nursing and Midwifery (May)	A consultation process was carried out nationally from March 2002 to March 2003. Workshops were held with Directors of Nursing and Midwifery, Directors of the Nursing and Midwifery Planning and Development Units, and nurses and midwives from all divisions of the register. Submissions were called for and 105 were received. The report benchmarks progress to date for general, midwifery, mental health, children's, intellectual disability and older person nursing and sets the agenda for a debate on options, direction and actions for the future. CPD emerges as the predominant issue in this

Year / Initiative / Report / Publication	Summary
	report for all areas of nursing to support developing nursing and midwifery practice in modern health structures.
Guidelines for Portfolio Development for Nurses and Midwives (September)	These guidelines are aimed at individual nurses and midwives working at the forefront of healthcare delivery, for the purpose of assisting them to identify, reflect upon and record the contribution they make to direct and indirect care, encouraging them to store records of their development in a coherent and structured manner and providing guidance and information on achieving their individual professional goals within the context of the needs of the health service.
Guidelines for Health Service Providers for the Selection of Nurses and Midwives who might apply for financial support in seeking opportunities to pursue further education (November)	This document was produced to assist managers of health services in the selection of individuals seeking financial support to pursue further education and professional development.
National Council Newsletter, Issues 9 to 12	The Newsletter continued to disseminate and analyse information of relevance to the profession, in particular detailed explanation and analysis of the Health Service Reform Programme was featured.
2004	
An Evaluation of the Effectiveness of the Role of the Clinical Nurse / Midwife Specialist (January)	This report benchmarks the progress of clinical specialism in nursing and midwifery in Ireland to the present time. Ireland is at an early stage of development of these roles within a formalised framework as set out by the Report of The Commission on Nursing (Government of Ireland 1998). The cohorts of CNSs/CMSs in post have clearly embraced the core concepts of the role and have been empowered to improve the quality of care for patients/clients: there is overwhelming support for the effectiveness of the role of the CNS/CMS. It is clear that there is great potential for the role to develop in its responsiveness to service need. This report outlines critical areas for progress and describes a process for future development of roles at local, regional and national levels. The report makes recommendations regarding role development, continuing professional development, development of posts and annual reviews of posts on a local, regional and national basis.
Report on the Continuing Professional Development of Staff Nurses and Staff Midwives (May)	There is growing evidence of the need to link CPD with organisational goals. This report examines CPD issues relevant to staff nurses and staff midwives by reviewing: CPD activities of staff nurses and midwives, competency achievement and maintenance relevant to service need and personal professional development of staff nurses and staff midwives and career choice relevant to CPD and competency of staff nurses and

Year / Initiative / Report / Publication	Summary
	staff midwives. In preparation for this report methodology included: a literature review, focus groups and questionnaire. Staff nurses from general, mental health, ID and children's nursing and staff midwives were invited to participate. Nurses and midwives from cities, towns and rural areas were represented, as were those working in community and in-patient settings. Recommendations are made concerning the development of structures to support CPD for staff nurses and staff midwives
Framework for the Establishment of Advance Nurse and Advanced Midwife Practitioner Posts, 2nd Edition (July)	This document, building on the framework outlined in the first edition outlines the background to the development of ANP/AMP posts in Ireland. It defines ANP/AMP roles and outlines the criteria that nurses and midwives must meet to in order to become ANPs/AMPs. It also provides guidance for managers, nurses and midwives who are working through the processes. Templates are provided to assist in the application processes.
Framework for the Establishment of Clinical Nurse / Midwife Specialist Posts, 2nd Edition (November)	This document, building on the 2001 edition, outlines the process for establishment of CNS/CMS posts and the criteria that nurses and midwives must meet in order to become CNSs/CMSs. Core competencies for CNS posts are provided.
National Council Newsletter, Issues 13 to 15	The National Council Newsletter continued to be used as platforms for the dissemination and analysis of information relevant to the development of nursing and midwifery within the Health Services. In particular, detailed analysis of the HSRP continued.
NCNM Quarterly Review, Issue 16	The nature of the information and analysis that had been provided in the National Council Newsletter had developed to such an extent at this point that it was consider appropriate to re-brand the Newsletter and it is now referred to as the NCNM Quarterly Review.
2005	
An Evaluation of the Extent and Nature of Nurse Led / Midwife Led Services in Ireland (April)	The terms of reference for the study were: to examine the literature pertaining to the nurse-led/midwife-led care services, identify the extent of nurse-led/midwife-led care services in Ireland and to make recommendations on future areas for developments for nurse-led/midwife-led care in Ireland. The methodology employed consisted of focus groups, questionnaire and a literature review. The diversity and multiplicity of the nurse/midwife led services in place would suggest that nurses and midwives are able to respond to patient/client need in a flexible and appropriate manner, allowing the development to occur within a

Year / Initiative / Report / Publication	Summary
	multidisciplinary context. To date these initiatives have been driven by service need and a desire by nurses and midwives, both at senior and clinical level to improve the quality of the patient/client care. It is also evident that as these services develop they are being audited and measured for clinical effectiveness and patient satisfaction. It is recommended that a business plan approach is adopted to aid the development of nurse-led/midwife-led services - a template to assist this is provided.
Clinical Nurse Specialist and Advanced Nurse Practitioner Roles in Emergency Departments: A Position Paper (April)	This position paper reviews progress of specialist and advanced practice in emergency departments to date, identifies key components of role development for specialist and advanced nursing practice within an emergency context and outlines the areas that require further development in order to enhance service. A focused needs assessment for managers is provided.
Agenda for the Future Professional Development of Public Health Nursing (June)	A consultation was carried out nationally from November 2004 to February 2005. Workshops were held with Directors of Public Health Nursing, Assistant Directors of Public Health Nursing, Public Health Nurses engaged in clinical practice and key stakeholders. The Report benchmarks progress to date and sets an agenda for future actions. The main concerns expressed by participants related to role clarity, workload demands, variation in service provision and delivery of care, the clinical career pathway, leadership, skill mix and multidisciplinary team working. The report sets an agenda for future actions.
A Study to Identify the Research Priorities for Nursing and Midwifery in Ireland (June)	Under the National Research Strategy for Nursing and Midwifery in Ireland, a study to identify the research priorities for nursing and midwifery in Ireland was carried out under the auspices of the National Council. The report was compiled by a team of researchers from UCD led by Dr. Therese Meehan (Meehan, 2005).
Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products – Final Report (June, jointly with An Bord Altranais)	This report is the culmination of a three and half year project conducted jointly by the National Council and An Bord Altranais. The report includes and updated literature review, legislative issues, policy developments, activity trail, education programme, current healthcare policy and recommendations. The report identified the need for nurses and midwives in Ireland to expand their medication management practices to include prescribing medications where appropriate.
Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products – Summary (June, jointly with An Bord Altranais)	This document provides a summary of the main report. This document provides guidance in the form of a framework for institutions and individuals involved in

Year / Initiative / Report / Publication	Summary
The Development of Joint Appointments: A Framework for Irish Nursing and Midwifery (September)	making joint appointments between services, voluntary organisations, educational institutions and / or other organisations. The report provides an overview of national and international literature and experiences. The need for clear structures and supports are identified as critical success factors. The National Council has created a framework assisting those involved in planning such roles.
Service Needs Analysis for Clinical Nurse / Midwife Specialists and Advanced Nurse / Midwife Practitioner Posts (September)	This paper identifies factors necessary for a service to conduct a needs analysis to determine whether Specialist or Advanced Practice levels of Nursing / Midwifery Practice are required to deliver a high quality service. A business case template is provided.
Preliminary Evaluation of the Role of the Advanced Nurse Practitioner (September)	This report shows that the roles have been successful where they have been introduced. The roles are spread over a wide variety of care areas, indicating that roles have developed in response to health service need. The strong clinical focus of the ANP role identified in the study suggests that one of the original aims of the Commission on Nursing (Government of Ireland, 1998), namely, the retention of expert nurses in direct patient care.
NCNM Quarterly Review, Issue 17 to 20	The Quarterly Review continues to be used as a platform for the analysis and dissemination of information of relevance to the profession in the context of developments within the Health Services.
2006	
Guidelines for Portfolio Development for Nurses and Midwives, 2nd Edition (February)	These guidelines are aimed at individual nurses and midwives working at the forefront of healthcare delivery, for the purpose of assisting them to identify, reflect upon and record the contribution they make to direct and indirect care, encouraging them to store records of their development in a coherent and structured manner and providing guidance and information on achieving their individual professional goals within the context of the needs of the health service. This publication provides an update on the original document published by the National Council in 2003. The document provides 14 sample record sheets and is accompanied by a CD containing Microsoft Word versions of the record sheets and an Adobe Acrobat pdf version of the Guidelines.
Report on the Baseline Survey of Research Activity in Irish Nursing and Midwifery (February)	This report provides a picture of nursing and midwifery research activity in Ireland for the period December 2002 to 2004. A number of recommended actions support the recommendations of the National Research Strategy for Nursing and Midwifery in Ireland (DoHC, p.9). Other recommendations are set out for building upon the baseline established by this project..

Year / Initiative / Report / Publication	Summary
A Guide to Sharing Practice and Quality Developments with Other Colleagues (June)	This publication is intended to help nurses and midwives prepare details of practice and quality developments for inclusion on the National Council's all-Ireland on-line practice and quality database.
Measurement of Nursing and Midwifery Interventions: Guidance and Resource Pack (September)	This is a two-part document. Part one contains a report on a study of nursing and midwifery interventions and the measurement of their outcomes taking place in Ireland. Part two contains the Guidance and Resource Pack, which aims to assist nurses, midwives and services to select and assess nursing and midwifery interventions as part of a quality improvement initiative. The document is accompanied by a CD containing Adobe Acrobat pdf versions of the two books.
Improving the Patient Journey – Understanding Integrated Care Pathways (September)	This publication aims to promote the use of integrated care pathways by nurses and midwives in order to improve the patient's journey.
NCNM Quarterly Review, Issues 21 to 24	The Quarterly Review continues to be used as a platform for the analysis and dissemination of information of relevance to the profession in the context of developments within the Health Services.

Appendix 6 – List of Approved ANP / AMP Posts (October, 2007)

AMP Posts approved
AMP (Women's Health) x 1
ANP Posts approved
ANP (Breast Care) x 1
ANP (Cardiology) x 2
ANP (Cardiothoracic) x 3
ANP (Care of the Older Person) x 1
ANP (Child & Adolescent Mental Health & Psychotherapy) x 1
ANP (Children's Emergency) x 2
ANP (Children's Renal) x 1
ANP (Cognitive Behavioural Therapy) x 2
ANP (Community Older Adults) x 1
ANP (Diabetes) x 3
ANP (Emergency) x 39
ANP (Emergency cardiology) x 1
ANP (Gastroenterology) x 1
ANP (Haematology) x 2
ANP (Haematology Oncology) x 1
ANP (Heart Failure) x 1
ANP (Neonatology) x 3
ANP (Older Person with Dementia) x 2
ANP (Oncology) x 3
ANP (Pain Management) x 1
ANP (Palliative Care) x 1
ANP (Primary Care) x 2
ANP (Rheumatology) x 1
ANP (Sexual Health) x 1
ANP (Stroke Care) x 1
ANP (Urology) x 1
ANP (Women's Health) x 2

Appendix 7 – List of Approved CNS / CMS Posts (October, 2007)

TITLE AND NUMBER OF POSTS	
Acute Mental Health	1
Acute Mental Health Care	1
Acute Pain Management	2
Addiction Counselling	24
Addiction Counsellor	24
Addictions	1
Addictions / Detoxification	2
Adolescent Mental Health	1
Adult Physical Disabilities and Rehabilitation	1
Adults with Autistic Spectrum Disorder	1
Adults with Chronic Physical Disabilities	1
Affective Disorders	5
Ageing Related Care	1
Airways Management	1
Airways/Tracheostomy	1
Alcohol Addiction Counselling	1
Alcohol Counselling	2
Alternative and Augmentative Communication	2
Alzheimer/Dementia Care	1
Anaesthetic Support	1
Anticoagulant	1
Apheresis	2
Assertive Outreach Mental Health	1
Asthma	4
Asylum Seeker Health Assessment	1
Attention Deficit/Hyperactive Disorder	1
Autism Hyperactive Disorder	1
Autism Therapist	2
Autistic Spectrum Disorders	1
Autotransfusion	3
Behaviour Management	8
Behaviour Nurse Challenging Behaviour Unit	1
Behaviour Nurse Psychotherapist	1
Behaviour Nurse Therapist	2
Behaviour Therapy	25
Behavioural Nurse Psychotherapist	1
Behavioural Psychotherapy	4
Behavioural Therapist	2
Behavioural Therapy	1
Bereavement	1
Bereavement Counselling	3
Bone Bank Co-ordinator	4
Bone Marrow Registry Co-ordination	1
Bone Marrow Transplant Co-ordinator	1
Bone Tumour	1
Brainwave Community, Epilepsy	1
Breast Care	23
Breastfeeding	1
Cancer Care	2

TITLE AND NUMBER OF POSTS	
Cancer Co-ordinator	3
CAPD	2
Cardiac Disease	1
Cardiac Disease Management	2
Cardiac Rehabilitation	27
Cardiac Services	4
Cardiology	10
Cardiology/Chest Pain	1
Cardio-Pulmonary Resuscitation	10
Cardio-Pulmonary Resuscitation - Neonatal	1
Care of the Elderly	1
Care of the Elderly-Learning Disabilities	1
Care of the Older Person	1
Challenging Behaviour	4
Challenging Behaviour Support	1
Chemotherapy	3
Chest Pain	7
Chest Pain Assessment	5
Child & Adolescent Mental Health	3
Child & Adolescent Psychiatry	5
Child & Adolescent Psychiatry Liaison	1
Child & Family Counselling	1
Child Psychiatry	1
Chronic Kidney Disease (Pre Renal)	1
Chronic Renal Failure	1
Cognitive Behaviour Therapy	1
Cognitive Behavioural Psychotherapist	1
Cognitive Behavioural Therapy	4
Coloproctology	2
Colorectal	2
Colposcopy	4
Community Child & Adolescent Psychiatry	36
Community Early Services	1
Community Gerontology	1
Community Intellectual Disability	4
Community Intellectual Disability Nursing	5
Community Mental Handicap	16
Community Mental Health	24
Community Mental Health Nurse	207
Community Mental Health-Older Person	1
Community Paediatrics	1
Community Psychiatry of Old Age	9
Community Rehabilitation of the Older Person	1
Complementary Therapies	1
Complementary Therapy	4
Complementary/Supportive Therapies	1
Complementary/Supportive Therapies (Older Persons)	1
Consultation Liaison Psychiatry	1
Continence Advice	4
Continence Advisor	1
Continence Management Elderly Care Services	2
Continence Promotion	9
Continence Promotion in Learning Disabilities	2

TITLE AND NUMBER OF POSTS	
Continence/Urodynamics	1
Continuous Ambulatory Peritoneal Dialysis	3
Counselling	10
Counselling & Psychotherapy	4
Counsellor	3
Creative, Diversional & Recreational Activation	10
Crisis Intervention	3
Crisis Intervention Liaison	1
Crisis Outreach Response	3
Critical Care	1
Cystic Fibrosis	16
Cystic Fibrosis Liaison	2
Deliberate Self Harm	1
Dementia	3
Dementia Care	6
Dermatology	23
Diabetes	62
Diabetes - Community	1
Diabetes - Primary Care	1
Diabetes / Endocrine	2
Diabetes and Obesity	1
Diabetes Liaison	1
Diabetes Liaison - Primary Care	1
Diabetes Nurse Education	1
Diabetic Care	1
Disabilities	3
Diversional & Recreational Activation	1
Diversional & Recreational Activation for the Older Person	1
Diversional Therapy	2
Divisional Therapy/Health Promotion	1
DOMINO Early Discharge Team	2
Drama Therapy	1
Drug Court	1
Drugs Liaison	3
Dyspnoea	1
Early Intervention	16
Early Intervention - Autism	1
Early Intervention - Disabilities	2
Eating Disorders	3
Elderly Assessment	1
Elderly Care	1
Emergency Practice	3
Endocrine Liaison	1
Endocrine Nurse Specialist	1
Enduring Mental Illness	1
ENT	1
ENT Assessment - Emergency Dept	1
ENT/Head and Neck	2
Epidermolysis Bullosa Liaison	1
Epilepsy	4
Epilepsy & Health Promotion	1
Falls / Osteoporosis	2
Falls/Blackouts	2

TITLE AND NUMBER OF POSTS	
Family & Marital Therapist	2
Family Therapist	8
Family Therapy	8
Family Therapy Nurse	1
Feeding & Nutrition	1
Foetal Assessment	7
Foetal Assessment & Ultrasonography	1
Functional Gerontology	1
Gastroenterology	3
General Practice	202
Genetics	1
Gerontological Assessment	1
Gerontological Rehabilitation	1
Gerontology	5
Haematology	13
Haematology/Inherited disorders of coagulation	1
Haematology/Oncology	3
Haematology/Oncology in Parent Education	1
Haemoglobinopathy	2
Haemophilia	2
Haemophilia & Related Disorders	2
Haemovigilance	15
Haemovigilance and Blood Transfusion	1
Haemovigilance/Transfusion Surveillance	1
Head & Neck Oncology	2
Health & Well Being	1
Health Advisor	4
Health Assessment and Promotion in the older adult	1
Health Promotion	1
Health Promotion & Intervention	4
Health Promotion & Intervention - Intellectual Disability Nursing	1
Health Promotion (Forensic)	2
Health Promotion and Intervention	1
Health Promotion for Ageing Adults with Intellectual Disability	1
Health Promotion in Intellectual Disabilities	1
Heart Efficiency	1
Heart Failure	9
Hepatitis C	1
Hepatitis C Liason	3
Hepatitis C Research	1
Hepatology	8
Hepatology, Hepatitis C	1
HIV/AIDS Liaison	2
HIV/Infectious Diseases	2
Home Based Mental Health Treatment	1
Home Based Treatment-Acute Psychiatry	8
Homelessness Liaison	1
Ilizarov Method	2
Immunology	1
Infection Control	53
Infection Control/Occupational Health	1
Infectious Disease Liaison	1
Infectious Diseases	2

TITLE AND NUMBER OF POSTS	
Integrative Counselling	3
Interventional Radiology	1
Invasive Cardiology	1
Joint Replacement	1
Lactation	12
Laser Therapy	1
Liaison (Self-Harm)	1
Liaison Mental Health	1
Liaison Psychiatry	5
Lithotripsy	1
Liver Transplant Coordinator	3
Lung Cancer	1
Lung Cancer Nursing	1
Lung Transplant Co-ordinator	1
Lymphodema	2
Male Genito - Urinary Cancer	1
Mammography	1
Mental Health Education	1
Mental Health in Adults with an Intellectual Disability	2
Mental Health Liaison	1
Mental Health Promotion	1
Mental Health Promotion & Intervention	1
Mental Health Rehabilitation	7
Metabolic Disorder	1
Migrane/Headache	1
Minor Injuries	3
Mobility and Therapeutic Interventions	1
Motor Neuron Disease Liaison	1
Multiple Sclerosis	3
Multiple Sclerosis/Neuro-Immunology	1
Neonatal	3
Neonatal & Paediatric Neurology	1
Neonatal Resuscitation	1
Neonatal Transition Home Service	1
Neonatology	1
Nephrology	3
Neurology	7
Neurology Liaison	1
Nutrition	1
Nutrition Support	1
Occupational Health	33
Old Age Psychiatry	2
Older People Nursing	2
Older Person Learning Disabilities	1
Oncology	45
Oncology Liaison	13
Oncology/Breast Care	1
Oncology/Palliative Care	1
Ophthalmology	12
Opthalmic Assessment - Emergency Dept	2
Orthopaedic Casting & Splinting	6
Orthopaedics	2
Osteoporosis	1

TITLE AND NUMBER OF POSTS	
Paediatric Casting	1
Paediatric Diabetes	4
Paediatric Ear Nose & Throat	1
Paediatric Endocrinology	1
Paediatric Haemodialysis	1
Paediatric Liaison	3
Paediatric Link Nurse	1
Paediatric Neurology	1
Paediatric Oncology	1
Paediatric Oncology Liaison	2
Paediatric Opthalmology	1
Paediatric Orthopaedics	1
Paediatric Pain	1
Paediatric Pain Management	1
Paediatric Radiology	1
Paediatric Renal	1
Paediatric Respiratory	2
Pain Control	5
Pain Management	9
Pain Medicine	1
Palliative Care	75
Palliative Care - Learning Disabilities	1
Palliative Care Inpatient Unit	1
Palliative Home Care	137
Parasuicide / Deliberate Self Harm	1
Parent Educator	1
Parkinsons Disease	1
Parkinson's Disease/Aspen	1
Peri-Anaesthesia	1
Peritoneal Dialysis	2
Personal Development Programmes	3
Physical & Mobility Habilitation	1
Physical Disability with Special Needs	2
Plaster Care - Paediatric	1
Pre Assessment	1
Pre Operative Assessment	1
Pre-school Learning Disability & Autism	1
Primary Care	1
Primary Care (Mental Health)	1
Psychiatric Consultation Liaison	2
Psychiatry of Old Age	1
Psychiatry of Old Age - Dementia Care	1
Psycho Oncology	1
Psychosis	1
Psychosocial Interventions	1
Psychotherapy	1
Psychotic Disorders	2
Rehabilitation - Mental Health	2
Rehabilitation Care of the Older Person	1
Rehabilitation Nursing	1
Renal	5
Renal - Pre Transplant	1
Renal Anaemia	1

TITLE AND NUMBER OF POSTS	
Renal Transplantation Services	1
Reproductive Health Care	2
Respiratory	29
Respiratory / Asthma	1
Respiratory Care	4
Respiratory Care, Sleep Disorders	2
Respiratory Medicine	1
Respiratory Nursing	1
Resuscitation	5
Rheumatology	16
School children with special needs	1
Sensory Integration & Therapeutic Programmes	1
Serious and Enduring Mental Illness	1
Sexual Health Promotion	1
Sexual Health/AIDS Liaison	1
Smoking Cessation	4
Smoking Cessation/Health Promotion	1
Social & Vocational Rehabilitation	1
Spinal Cord Injury - Liaison Nursing Service	1
Stem Cell	1
Stoma and Breast Care	1
Stoma Care	20
Stomatherapy	2
Stress Management/Bio-Feedback	1
Stroke Care	3
Stroke Management / Rehabilitation	1
Stroke Rehabilitation	1
Substance Misuse	2
Substance Misuse Counsellor	1
Supported Living	1
Surgical Liaison	1
Surgical Pre-Assessment Clinic	1
Systemic Family Therapy	2
Therapeutic Apheresis	1
Therapeutic Interventions in Elderly Care	1
Therapeutic Programmes	13
Therapies, Mental Health Care for Older People	1
Tissue Viability	23
Transfusion / Haemovigilance	1
Transfusion Surveillance	10
Transplant Liaison	1
Trauma and Minor Injuries	1
Treatment of Alcohol & Drug Use Disorders	1
Treatment Resistive Schizophrenia	1
Ultrasonography	2
Ultrasonography & Early Pregnancy Assessment	1
Ultrasound	4
Ultrasound and Foetal Assessment	4
Upper G.I. Cancer	1
Urodynamics	7
Urodynamics & Continence Promotion	1
Urodynamics/Rectal Manometry	1
Urology	8

TITLE AND NUMBER OF POSTS	
Vascular	1
Vocational Rehabilitation	5
Wound Care	5
Wound Care / Tissue Viability	1
Young Persons Substance Misuse	1

Appendix 8 – Type of Nurse-led / Midwife-led Service and Numbers of Years Established

Type of service	Years established
Adult tissue viability clinic	7
Adult pre-assessment day-care	4
Adult renal transplantation services	2
Adult haemocromatosis services	2
Adult pre-admission elective orthopaedics	2
Admission/discharge planning	3-4
Advanced nurse practitioner – Accident & Emergence service	1
Alzheimer unit	3
Assessment and case management in day hospital	3
Asylum seekers	2
Behavioural therapy	10
Blood collection clinics	2
Bone densitometry estimation	3
Cardiac rehabilitation	5
Care of older person	34
Case management	4
Case manager home subvention	1-10
Child health screening	20-34
Cognitive behavioural therapy	5-8
Colposcopy services	10
Community alcohol & substance misuse counselling services	7-8
Community midwifery	6
Community programme (mental health)	18
Continence assessment and management	4-28[58]
Continuing care	Not specified
Convalescence care	3-15
Day care services	8-20
Deliberate self-harm liaison nurse	2
Dementia care services	6
Developing care plans	4
Diabetes	3
Disability service – assessment of needs	34
Ear irrigation	5
Early transfer home scheme	2
Extended care	20
Family therapy services	4
Foetal assessment	4
Generic counsellor: day services -	3

[58] Where the years are in multiples more than one services provides this care, the range of years established are given.

Haemodialysis treatment	9
Heart failure	2-3
Home care	15
Hospice day care	11
Lactation	5
Leg ulcer clinic	1-4
Lymphoedema clinic	7
Midwife-led clinic	6
Midwifery-led unit	6 months
Midwives' clinics	15
Minor injuries A & E	3
Occupational health	5
Oncology services	3
Outreach clinics	3
Paediatric cystic fibrosis clinic	14
Paediatric/Adult diabetes services	14/5
Paediatric endocrinology	9
Paediatric respiratory services	7
Paediatric/adult dermatology	7/2
Paediatric urology	7
Palliative care	1-14
Parent craft classes	6-25
Patient assessment	4
Postnatal care	15
Primary care wound clinic	5
Rehabilitation services	2
Residential services	50
Respiratory nurse clinic	3
Respite care	3-10
Respite care (crisis)	8
Respite care (planned)	8
School screening	34
School service	20-30
Substance abuse service	Not supplied
Therapeutic aphaeresis service	8 months
Travellers' service	10
Urodynamics	3
Wound care including leg ulcer management – practice nursing	1-6
Women's health – practice nursing	1-6

Appendix 9 – Type of Service that Directors of Nursing / Midwifery are intending to introduce in the future

Reality and cognitive behavioural sessions with self-referral to a nurse-led community service
Day care service for older people
Rheumatology
ANP in pain management
Out patient cataract nurse-led clinic
Incontinence care in the older person
Health promotion in the elderly
Nurse-led pre-admission assessment service
Challenging behaviour
Holistic assessment of clients in the community who may require elderly care
Nurse-led clinic for clients with enduring mental health difficulties
Nurse-led liaison service (Mental health)
Nurse-led community detoxification programme
Diabetic ANP
Nurse-led colposcopy clinic
Midwife-led early miscarriage clinic
Midwife-led admissions and discharges
Tissue viability
Nurse-led pain management
Midwifery-led clinics
Pre-/post-HIV testing sessions
Nurse-led palliative care via ANP posts
Nurse-led care and case management (community care)
Nurse-led falls clinic
Nurse-led therapeutic day hospital
Midwifery-led ultrasonography service
Midwifery-led postnatal clinics
Midwifery-led breast-feeding support groups
Nurse-led mental health promotion
Nurse-led mental health rehabilitation
Nurse-led cognitive behavioural psychotherapy
Review of home birth services
Eating, drinking and swallowing nurse-led clinic
Nurse-led glaucoma clinic
Nurse-led therapeutic apheresis
Nurse-led platelet apheresis
ANP radiation induced toxicities
Midwifery-led services for healthy women likely to have a normal pregnancy and labour
Nurse-led child health primary screening
Nurse-led cervical cytology clinics
Nurse-led community leg ulcer clinics
Nurse-led enuresis treatment clinic
Nurse-led child health service

Appendix 10 – Recommendations from the Five Points Study

In June 2004, An Bord Altranais commissioned a team of researchers from the Nursing and Midwifery Research Unit, School of Nursing, Midwifery and Health Systems, University College Dublin, to undertake a study into the points of entry into Irish Nursing. This study became known as the *Five Points Project*[59] and was concluded in November 2005. The terms of reference of the study included the requirement to examine the rationale for and impact of maintaining the points of entry in respect of general nursing, psychiatric nursing, intellectual disability nursing, children's nursing and midwifery.

The study concluded with a series of recommendations that summarise the overall approach to pre-registration entry to nursing and midwifery education that prevails in Ireland today. These were:

1. Distinct registration education programmes should be retained in each of the five divisions of the Register. This recommendation permits the nurse or midwife to develop the knowledge and the competencies to undertake the discipline specific role for the division. This recommendation recognises the existence of unique client groups with unique needs and further recognises that there are various aspects of the health of the population, which need to be addressed by nurses and midwives with specialist training.

2. The report endorsed the proposal to introduce pre-registration midwifery education and training[60]. The report concluded that the expanding role of midwifery, especially in relation to midwifery-led services, would best be met through the expansion of pre-registration midwifery programmes.

[59] Available to download at http://www.nursingboard.ie/en/spon-five_points.aspx

[60] Direct entry midwifery programmes were subsequently introduced in 2006.

3. The pre-registration midwifery programme of education and training should not be the only route of entry into midwifery education and training, and a post-registration entry option should be retained.

4. The report also endorsed the proposal to introduce an integrated general and children's nursing degree programme[61].

5. The post-registration option for entry into children's nursing should be retained.

6. Intellectual disability nursing should remain as a distinct division of the register.

7. The post-registration option for entry into general nursing, psychiatric nursing and intellectual disability nursing should be re-introduced for nurses wishing to practice in these disciplines[62].

[61] The combined children's and general pre-registration degree programme was subsequently introduced in 2006.

[62] This has not yet been introduced (August 2007), however active consideration is being given to the introduction of this option for psychiatric nursing.

Appendix 11 – Information on the Bologna Declaration

The Bologna Declaration[63] was signed by 31 representatives of 29 EU member states and accession candidates. It declares that by 2010 the following aims shall be reached[64]:

1. A system of easily readable and comparable degrees shall be introduced, supported by the implementation of the Diploma Supplement.
2. Higher education course systems shall be based on two consecutive cycles: the undergraduate cycle, lasting three years, shall qualify students for employment, whereas the graduate cycle shall lead to Master's and/or doctorate degrees.
3. In order to ensure student mobility through the transferability of their achievements, a credit system similar to ECTS shall be launched; credits shall also be obtainable in non-HE contexts such as life-long learning.
4. Student mobility and free movement shall be promoted.
5. European co-operation in quality assurance shall be established.
6. The European dimension shall be promoted in HE through curricula, inter-institutional co-operation and mobility schemes for both students and teachers/researchers.

The Ministers for Education participating in the Bologna Process met in London in May 2007[65] and reaffirmed their commitment to the process. They stated that the aim is to replace the Bologna Process with the European Higher Education Area (EHEA) by 2010 and that by then there would be a single three year degree programme at undergraduate level throughout the area, with mutually recognised standards and accreditation. The purpose of this is to increase mobility and employability through the area.

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[63] European Higher Education Area – Joint Declaration of the European Ministers of Education convened in Bologna on 19 June 1999

[64] http://www.hefce.ac.uk/partners/world/bol/

[65] http://www.dfes.gov.uk/londonbologna/

Appendix 12 – PRERG Terms of Reference

The terms of reference for the group include:

1. To prepare a comprehensive strategy for the development, delivery and evaluation of post-registration nursing and midwifery education. Preparation of the strategy will include reference to the following:
    a. Service requirements
    b. Professional requirements
    c. Relationship between professional competence and quality of patient care and safety
    d. Core principles of the Health Service Reform Programme
    e. Value for Money including sponsorship arrangements and monitoring service commitments
    f. Availability of clinical placements
    g. Access
    h. Geographical spread of educational provision
    i. Modes of delivery.
    j. Existing partnerships between health service providers and Higher Education Institutions
    k. Potential for multi-professional education
    l. Existing related national and international legislation, policies and strategies, e.g. NQAI framework
    m. Progression and Transferability issues

2. The Strategy will be informed by:
    a. A baseline study which clearly details the existing scale of provision of post-registration nursing and midwifery education programmes and takes account of arrangements for and amount of health service funding.
    b. An examination of the need for the provision of post-registration programmes leading to registration with An Bord Altranais.

3. The strategy will result in the publication of an overarching framework for the development of future post-registration programmes including a preferred model for procuring and financing the development and delivery of these programmes.

Appendix 13 – PRERG Recommendations

The PRERG commissioned a literature review to support and inform its deliberations and recommendations. This review was carried out by a team of researchers at the Catherine McCauley School of Nursing and Midwifery, University College Cork. An interim report was produced in May 2007 and a final report was produced in July 2007.

The review concluded with a series of recommendations in the areas of practice, education, policy and research:

Practice

- Consider the personal, professional and employment histories of staff wishing to pursue courses
- Ensure that the burden for balancing personal and employment concerns are shared between nurses and midwives and their organisations
- Ensure that nurses and midwives work in an environment in which new, innovative, relevant and appropriate practices are fostered and developed
- Ensure services are developed to absorb nurses and midwives with newly acquired skills and knowledge
- Recognise that nurses and midwives require additional support and supervision to apply their newly acquired knowledge and skills
- Adopt a rigorous micro-level training needs analysis in organisations, and use a model to evaluate the effectiveness of the process and outcomes of future training needs analysis initiatives

Education

- Greater collaboration between universities and health service providers to determine local and regional needs, and to foster a more coordinated approach to programme design and delivery

- Changes in educational methods, approaches to meet the diverse and complex needs of future students
- Develop more creative approaches in course design and delivery
- Ensure that courses are up to date, relevant, contemporary and responsive to current and future health service needs
- Include modules/courses which focus on directing the implementation of change rather than on the implementation of change itself
- Improve availability of and access to courses in various areas of practice, such as child and adolescent mental health care
- Consider interprofessional education programmes, for example in a work based learning format to local interprofessional teams to ensure maximum impact on personal participation, effective team work and change in service delivery
- Consider and agree robust and systematic evaluation frameworks, such as developed by Barr (1999), Carpenter et al (2006) and Brooker and Curran (2005) at a national level to guide course development, implementation, monitoring and evaluation
- Consider the use of Accreditation of Prior and Experiential Learning [AP(E)L]
- Recognise that course content can be taught at different levels
- Consider the development of professional/practice doctoral education
- Consider the needs of lecturers responsible for developing and delivering post-registration and postgraduate programmes
- Consider employment of consumer as academic staff member

Policy

- Provide a comprehensive, creative and transparent post-registration and postgraduate education strategy and framework, which is equitable, well resourced, and which takes into account the needs of all the stake holders
- Undertake a comprehensive post-registration and postgraduate needs analysis

- Provide funding to develop reliable measures to evaluate skill development and implementation
- Facilitate the development and subsequent research of the benefit of interprofessional education and practice
- Disseminate guidance on adopting a systematic approach to course and programme evaluation
- Consider the development of post-registration and postgraduate education programmes for midwives and intellectual disability nurses as a matter of urgency
- Consider the development of a comprehensive national doctoral education strategy

Research

- Set up appropriate research designs to capture all elements of the impact of programmes on practice, preferably longitudinal studies, and well controlled trials, and studies which focus on particular on organisational and service delivery changes, and on patient and carer outcomes.
- Ensure the evaluation of midwifery and intellectual disability nursing programmes
- Consider comparative studies, to compare the impact of different educational approaches on aspects of practice
- Evaluate the impact of nurses and midwives taking non-nursing or non-midwifery postgraduate programmes

Appendix 14 – The SWTRHA Career Development and Planning System

Key Competencies for Nursing Directors.

1. Sees the organisation as a total system: takes a helicopter view of the trust as a whole, within a bigger healthcare system.
2. Challenges the status quo: thinks innovatively and creatively about new ways of doing things to improve organisational practice.
3. Employs personal networks to promote change: gains the respect and credibility of others.
4. Builds constructive relationships with non-nurse management: builds teams; is diplomatic and receptive to others' points of view; possesses clarity about own and others' roles.
5. Articulates what constitutes effective patient care: demonstrates a commitment to healthcare and the importance of the patient as a customer deserving of the highest quality of care.
6. Motivates nurses to bring about change: displays strong leadership skills; employs, effective communication skills; recognises the importance of encouraging feedback from the workforce.
7. Champions the human consequences of change: understands the need for people to have time to acclimatise to change; anticipates the impact of change on the organisation and takes appropriate steps to address it; recognises the importance of people to the development of the organisation.
8. Influences planning and management of change: understands the importance of clarity about what is to be achieved; establishes goals for its achievement and monitors progress; understands the value of projects in promoting involvement in change and develops ownership of the change process.
9. Uses basic concepts of business management: understands the fundamental elements and processes of running a successful independent business enterprise.

10. Understands the evolving role of the nursing director: identifies the development needs of self and others; assesses and judges people's potential for career advancement.
11. Effectively delegates decision making to others: understands the importance of supporting others' development; involve them directly in activities for which they will assume authority; is tolerant of their mistakes as part of the learning process and progressively releases control. (South West Thames Regional Health Authority, 1992, *A competency framework for trust nursing directors*).

Appendix 15 – Letter to Participants in Interviews

Date……

Title – Name
Address 1
Address 2
Address 3
Address 4

Re: **An Examination of the Strategic Challenges Facing Nursing and Midwifery in a Changed Health Service**

Dear Name…

I am currently enrolled as a Research Student at the Faculty of Health Sciences in Trinity College Dublin. In fulfilment of the research requirements, I am undertaking research into the above theme.

The aim of this study is to identify the professional development challenges that nursing and midwifery in Ireland will face within a changed health service and to formulate a strategy to face those challenges.

Since the publication of the Health Strategy *Quality and Fairness – A Health System for You*, and the more recent *Health Service Reform Programme*, in particular the Prospectus Report, the Brennan Report and the Hanly Report (*Report of the National Taskforce on Medical Staffing*), it has become clear that the health services in Ireland are about to undergo major organisational and cultural change. Nursing and midwifery make up 35% of the total health care workforce and are the largest single group of professionals within the health services.

The central question to be addressed through the research will be – What is the future role for nursing and midwifery within the Irish Health Services?

I would like to invite you to participate in this research. In particular I would like to invite you to agree to a semi-structured interview that will address the central question of the research. The interview will take about one hour. I am attaching an information sheet that contains a more detailed description of what is involved and a brief guide to the topics I would like to discuss with you at the interview.

If you agree to take part, your contribution to this research will be treated with complete confidentiality. Your input will be aggregated to that of the other participants and not revealed to any other individual.

I will contact your office by telephone to check your availability and, hopefully, to agree a mutually agreeable time.

Thank you for your cooperation. I am sure you understand the importance of the theme being addressed, its appropriateness at this time of change within the health service. Your particular contribution will be highly valued and add significantly to the value of the findings.

Yours sincerely,

_____
Yvonne O'Shea

Appendix 16 – Letter to Participants in Focus Groups

Date……

Title – Name
Address 1
Address 2
Address 3
Address 4

Re: **An Examination of the Strategic Challenges Facing Nursing and Midwifery in a Changed Health Service**

Dear Name…

I am currently enrolled as a Research Student at the Faculty of Health Sciences in Trinity College Dublin. In fulfilment of the research requirements, I am undertaking research into the above theme.

The aim of this study is to identify the professional development challenges that nursing and midwifery in Ireland will face within a changed health service and to formulate a strategy to face those challenges.

Since the publication of the Health Strategy *Quality and Fairness – A Health System for You*, and the more recent *Health Service Reform Programme*, in particular the Prospectus Report, the Brennan Report and the Hanly Report (*Report of the National Taskforce on Medical Staffing*), it has become clear that the health services in Ireland are about to undergo major organisational and cultural change. Nursing and midwifery make up 35% of the total health care workforce and are the largest single group of professionals within the health services.

The central question to be addressed through the research will be – What is the future role for nursing and midwifery within the Irish Health Services?

I would like to invite you to participate in this research. In particular I would like to invite you to agree to participate in a focus group that will address the central question of the research. The focus group will take about one hour. I am attaching an information sheet that contains a more detailed description of what is involved.

If you agree to take part, your contribution to this research will be treated with complete confidentiality. Your input will be aggregated to that of the other participants and not revealed to any other individual.

I will contact your office by telephone to check your availability and, hopefully, to agree a mutually agreeable time.

Thank you for your cooperation. I am sure you understand the importance of the theme being addressed, its appropriateness at this time of change within the health service. Your particular contribution will be highly valued and add significantly to the value of the findings.

Yours sincerely,

_____
Yvonne O'Shea

Appendix 17 – Information Sheet for Participants

You have been invited to participate in a research exercise into issues of direct relevance to the future of nursing and midwifery in Ireland. The following information provides you with a summary the key information you will need. Should you require any clarification or additional information, please contact the researcher directly.

1. The research is being conducted by Yvonne O'Shea and is part fulfilment of the research requirements of her studies at the Faculty of Health Sciences in Trinity College Dublin.

2. The title of the research study is An Examination of the Strategic Challenges Facing Nursing and Midwifery in a Changed Health Service. The aim of the research is to identify the professional development challenges facing nursing and midwifery within a changed health service and to formulate a strategy to face those challenges.

3. The primary research consists of a number of face-to-face semi-structured interviews with selected individuals in policy making, service management and clinical service within the Health Services. In addition a number of focus groups will be held with a targeted number of health care professionals.

4. The face-to-face interviews will be conducted at a location of the participant's choosing. The identity of interviewees will not be revealed. The findings of these interviews will be aggregated for the purpose of thematic coded analysis.

5. The venue for the focus groups will be discussed with the participants and is likely to be at a hotel convenient to participants in a meeting room rented for the purpose. The ground rules for the focus groups will be discussed with participants at the outset. These will be designed to guarantee participants privacy and confidentiality.

6. In order to facilitate accuracy of analysis and coding, the interviews and focus groups will be taped and transcribed. Copies of transcribed interviews and focus group findings can be made available to the immediate participants who request them. Copies will not be made available to any third parties.

7. Your participation in this research is totally voluntary. You may withdraw at any moment without needing to give any explanation. The researcher guarantees your right to privacy and confidentiality at all stages of the research.

Thank you for your cooperation.

Yvonne O'Shea.

Appendix 18 – Interview Schedule for Semi-structured Interviews and for Focus Groups

INTRODUCTION –

- **Personal introduction and background (3 minutes)**
- **Purpose of the research (5 minutes)**
  - **Impact of HSRP on Nursing and Midwifery**
  - **Role of Nursing and Midwifery into the future (5 – 10 years)**
  - **Six years since Commission on Nursing – changed context; time to review**
  - **Professional Development implications of changes ahead.**
  - **Plan for development strategy for Nursing and Midwifery**
- **Permissions – sign consent form; agree to taping (1 minute)**
- **Agree on follow-up if needed**

	Questions	Probe For
1.	What do you think will be the major contextual changes for the health services of the future?	➢ Changing socio-economic environment ➢ Future direction of policy ➢ Economic impacts ➢ Political impacts ➢ Social changes ➢ Other?
2.	How would you describe the most likely future shape of the Irish health services?	➢ Separation of Policy and Executive functions ➢ Changes in organisational structures? ➢ Changes in delivery mechanisms? ➢ Acute vs. primary? ➢ Changes in accountability? ➢ Changes in culture? ➢ Changes in role? ➢ Changes in size? ➢ Changes in epidemiology?
3.	Do you think the role of nurses and midwives will change significantly over the next 10 years? (If no – explain why not; if yes – In what way will it change?)	➢ Nurse led services ➢ Proactive in change initiative ➢ Proactive adaptation to service needs ➢ Interdisciplinary teams
4.	In what way do you think the new role will differ from the current role?	➢ Relations between acute and primary settings ➢ Prescribing ➢ Education ➢ Specialisation ➢ Involvement in management

		➢ Accountability
5.	Do you think that General Managers and Nurse Managers understand the way in which the role of nurses and midwives will change?	➢ Preparedness for change? ➢ If no – why do you think that is and what should be done to change it? ➢ If yes – how do you think this was achieved and how is it demonstrated? ➢ Depth of understanding of the problems and issues within the existing structures?
6.	In what way will the relationships between the various professions and grades involved in the delivery of health services change in the future?	➢ Common education? ➢ Team working? ➢ The management and cultural implications
7.	What do you think are the key skills and competencies that nurses and midwives will need to develop to fulfil their role within the future health services?	➢ Specialisation ➢ Interdisciplinarity ➢ Working in teams ➢ Boundary spanning ➢ Management ➢ Research ➢ People management ➢ Communication ➢ Financial skills
8.	In what way do these new skills differ from the present range of skills?	
9.	Do you believe that on the whole nurses and midwives already have these skills? (If no – why? If yes – are there any additional skills that will be needed?)	➢ Appropriateness of education and training?
10	What are your opinions on the current level of preparedness of nurses and midwives for the challenges ahead?	➢ Recent changes ➢ Impact of Commission on Nursing ➢ Quality or lack of quality of CPD?
11	How would you assess the appropriateness of the current range of educational provisions for nurses and midwives in view of the changes ahead?	➢ Aware of recent changes? ➢ Pre-registration and post-egistration ➢ CPD? ➢ Matched to needs?
12	What changes would you suggest in the provision of education and training for nurses and midwives?	➢ Common basic education for clinical professionals? ➢ Multidisciplinary ➢ Broader basic education within the degree?

Appendix 19 – Thank You Letter to Participants

Letter to all interviewees and participants in research

Name

Address

Date

Dear…

This is just a note to thank you for your valuable contribution to the research *An Examination of the Strategic Challenges Facing Nursing and Midwifery in a Changed Health Service*.

I appreciate very much the time you took out for the interview and the consideration you gave to your replies to the questions in the semi-structured interview.

Yours sincerely,

Yvonne O'Shea

Appendix 20 – Informed Consent Form

Project: An Examination of the Strategic Challenges Facing Nursing and Midwifery in a Changed Health Service

Principal Investigators: Yvonne O'Shea

Background:

The aim of this study is to identify the professional development challenges that nursing and midwifery in Ireland will face within a changed health service and to formulate a strategy to face those challenges.

Since the publication of the Health Strategy *Quality and Fairness – A Health System for You*, and the more recent *Health Service Reform Programme*, in particular the Prospectus Report, the Brennan Report and the as yet unpublished Hanly Report (*Report of the National Taskforce on Medical Staffing*), it has become clear that the health services in Ireland are about to undergo major organisational and cultural change. Nursing and midwifery make up 35% of the total health care workforce and are the largest single group of professionals within the health services.

The central question to be addressed through the research will be – What is the future role for nursing and midwifery within the Irish Health Services?

Procedures: The study will consist of a series of semi-structured interviews and focus groups with senior personnel responsible for the development and implementation of policies and the management of the health services. Participants in the research have been selected based on their involvement in areas of the health service that are likely to impact on the future role of nurses and midwives.

Declaration:

This study and this consent form have been explained to me. The investigator(s) has/have answered all my questions to my satisfaction. I understand what will happen if I agree to be part of this study.

I have read, or had read to me, this consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I have received a copy of this agreement.

I understand I may withdraw from the study at any time.

PARTICIPANT'S NAME: **……..**

CONTACT DETAILS: ……..

PARTICIPANT'S SIGNATURE: ……..

Date:……..

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:……

Date:…….

(Keep the original of this form in the investigator's file, give one copy to the participant.)

Appendix 21 – Submission to Ethics Committee

RESEARCH Ethics application CHECKLIST

To process your application form efficiently you are required to fill in the checklist below. Do not leave any blanks. Please note that your application will be returned to you <u>on receipt</u> if the answer to any of the following is NO or N/A, without adequate justification.
If your proposal has been approved by the ST JAMES'S HOSPITAL AND FEDERATED DUBLIN VOLUNTARY HOSPITALS JOINT RESEARCH ETHICS COMMITTEE (JREC), since this body includes representation from Trinity College there is no requirement to seek approval from the Faculty Ethics Committee.

	YES	NO	N/A	IF NO OR N/A, PLEASE JUSTIFY
1. Are you undertaking the proposed research study in your capacity as a student of the Faculty of Health Sciences?	Yes			(If YES your supervisor must endorse the form)
2. Are you undertaking the proposed research study in your capacity as a staff member of the Faculty of Health Sciences?		No		I am not a staff member of the Faculty of Health Sciences. I am undertaking the study in my own capacity and in my capacity as a student of the Faculty.
3. Does the proposed research involve current students and / or staff of the Faculty of Health Sciences as research subjects?		No		The study does not involve current students or members of staff as research students.
4. If you are a student, has your supervisor endorsed the form?	Yes			
5. Have you attached the consent form you propose using?	Yes			
6. Have you attached the letter(s) to prospective participants seeking their co-operation with the study?	Yes			
7. Have you attached the participant information leaflet you propose using?	Yes			
8. If the study requires access to a site outside your home department/School, have you attached the letter(s) seeking access to appropriate sites?			N/A	Study does not require access to any sites for which permission is required. Interviews and Focus groups will be held in neutral locations.
9. If the study requires access to subjects whose welfare is the responsibility of somebody else, have you attached the letter seeking this access?			N/A	The study does not involve research among subjects whose welfare is the responsibility of somebody else.
10. If the study requires ethical approval by ethics committees of any other institutions, have you attached a copy of the responses received from these committees?			N/A	The study does not require the approval of any other ethics committee.
11. Have you attached a copy of the tool(s) of data collection you propose using? (Questionnaire / interview schedule / observation schedule)	Yes			
12. Have you included justification of the tool(s) proposed?	Yes			
13. Have you included justification for the sample size selected for investigation?	Yes			

TRINITY COLLEGE
Faculty of Health Sciences
RESEARCH ETHICS APPLICATION FORM
CONFIDENTIAL

Please complete all information relevant to your application

SECTION 1 – APPLICANTS' DETAILS

1.1. Name, qualification and position of each person associated with this research project.
List details of all personnel involved with the research (excluding participants)

Investigator Title / First name / Surname	**Primary Employer (Hospital / University / Other)**	**Professional Qualifications**	**Address**	**Tel No Work / Home**	**Bleep/Fax**	**Email address**	**Title of Position**	**Role in research**
Mrs. Yvonne O'Shea	National Council for the Professional Development of Nursing and Midwifery (NCNM)	RGN, RM, RNT, BA (Health Management), MSc.Econ.	6/7 Manor Street Business Park, Manor Street Dublin 7	01.8825310	01.8680366	yos@indigo.ie	Chief Executive	Principal
Supervisor (if investigator is a student)	**Primary Employer (Hospital / University / Other)**	**Professional Qualifications**	**Address**	**Tel No Work / Home**	**Bleep/Fax**	**Email address**	**Title of Position**	**Role in research**
Prof. Cecily Begley	School of Nursing / Midwifery Faculty of Health Sciences	RGN, RM, PhD	School of Nursing / Midwifery Faculty of Health Sciences Trinity College Dublin Dublin 2	01.6082693		cbegley@tcd.ie	Professor	Supervisor

SECTION 2 – DETAILS OF RESEARCH STUDY

2.1 Title of study *(Please enter the full title of the study)*

An Examination of the Strategic Challenges Facing Nursing and Midwifery in a Changed Health Service

2.2 Dates & Duration of Study

Proposed Start Date:	**October 2003**	**Proposed End Date:**	**September 2006**

2.3 List the primary location(s) where this study will take place

Semi-structured interviews will be held in the offices of the participants (i.e. Health Service Policy Makers and those responsible for the implementation of policy, Health Service Managers and in particular Clinical Managers, Medical consultants and Nurse Managers).	*Focus Groups will be held in neutral venues outside the place of work of those involved (most likely in rooms rented for the purpose) with Clinical Managers (Directors of Nursing and Midwifery Planning and Development Units), Directors of Nursing, Educators in Third level institutions.*

2.4 Research aim(s) and objective(s), research question, hypothesis (as appropriate)

The **central question** to be addressed by this research is – **What is the future role for nursing and midwifery within the Irish health services?** The context within which this question is asked is the ongoing reform of the health services and the fact that it is envisaged that this role should change (this is made clear in the review of literature, in particular the review of recent policy documents in Ireland).

The central question is intended to generate information that will help us to –

1) Identify and analyse the contexts (policy, economic, organisational, institutional) within which the health services of the future will be delivered.
2) Describe the likely future shape of the Irish health services
3) Describe as clearly as possible the new role that is intended for nurses and midwives within the services
4) Describe in what way this role differs from the current role
5) Assess the degree of clarity and certainty (or of confusion and uncertainty) and of awareness and understanding that exists among key stakeholders in relation to the definition of this role
6) Understand the nature of the relationships that will need to be developed

A substantive **supplementary question** to be addressed is – **What are the professional development implications of this future role?**

There are two assumptions underlying the supplementary question – The first assumption is that changes of role will require the development of new skills and competencies; the second assumption is that changes of role will require the forging of new relationships within policy, institutional and organisational contexts.

The supplementary question is intended to generate information that will help us to –

7) Identify the skills and competencies that will be required to fulfil the new role

8) Assess whether or not these skills and competencies are different from those that are currently required

9) Assess perceptions as to whether or not nurses and midwives currently possess the necessary skills and competencies

This information will then be used to –

10) Assess the level of preparedness of nurses and midwives to work within the dynamics of the new relationship and contexts

11) Assess the adequacy of the current provision of professional development opportunities for nurses and midwives (at pre-registration and post-registration levels) to prepare them for the challenges inherent in the new role that is envisaged for them

12) Identify what changes would be required to the provision of professional development opportunities to ensure that in the future nurses and midwives are adequately prepared for their role.

13) To formulate a professional development strategy for nursing and midwifery adapted to the likely pace of change within the health services and capable of addressing the needs of the profession.

The central question and the supplementary question provide us with the overall aims of the research. The thirteen points outlined above provide us with the specific objectives of the research.

2.5 Provide brief outline of the project (maximum 300 words to include background, research approach, design, data collection methods, sampling etc.)

Since the publication of the Health Strategy *Quality and Fairness – A Health System for You*, and the more recent *Health Service Reform Programme*, in particular the Prospectus Report, the Brennan Report and the Hanly Report (*Report of the National Taskforce on Medical Staffing*), it has become clear that the health services in Ireland are about to undergo major organisational and cultural change. Nursing and midwifery make up 35% of the total health care workforce and are the largest single group of professionals within the health services.

The *Report of the Commission on Nursing – A Blueprint for the Future* (Stationery Office, 1998) contained the most comprehensive review of the profession of nursing and midwifery that has ever been conducted in Ireland. The environment has however changed significantly within the last five years. Political, economic, institutional, professional and educational challenges face the profession now that were not present then. Nursing and midwifery need leadership now to consolidate the progress made as a result of the Commission on Nursing, to ensure that it is not lost within the new changes, and to influence the direction of change within the services in way that take account of the contribution that the profession can make to the achievement of the stated goals of equity and fairness for all. This research has the potential to provide the platform on which this leadership can emerge and thrive.

The research is a qualitative study and will consist of primary research among key stakeholders within the health services involved in the determination of the future shape of the health services and the role of nursing and midwifery within these services. The qualitative primary research will consist of semi-structured interviews and focus groups aimed at addressing the questions implicit in the objectives that have been identified for the research (see section 2.4 of this form). A description of the sampling and selection procedures to be used is provided in section 3.1.1. The data will be analysed using thematic content analysis (see section 3.1.4).

The research will be carried out by Yvonne O'Shea of the National Council for the Professional Development of Nursing and Midwifery (NCNM). A small number of the participants in the research would have an ongoing professional relationship with the NCNM in the area of professional development for nursing and midwifery, however they are all autonomous professionals who do not have a reporting relationship to the NCNM. Over the last two years, a number of research exercises of this nature have been carried out by the staff of the NCNM with the participation of these people (e.g. the evaluation of the role of Clinical Nurse and Midwife Specialists, evaluation of the professional developments needs of Staff Nurses and Midwives…). With this ongoing relationship, there is a slight possibility of additional bias being introduced because of the role of the principal researcher. The highest standards of Data Protection and confidentiality have always been exercised by the NCNM. Confidentiality will be assured by the aggregation of data and the use of numbers in the coding of transcripts (see section 3.3). In the past participants have expressed their opinions on these kinds of issues without apparent concerns regarding their confidentiality.

2.6 Have the researchers the required competence to employ the proposed evaluative measures correctly?

YES	Yes	NO		If NO, please explain how you propose to become competent

SECTION 3 - ETHICAL CONSIDERATIONS

3.1 Recruitment and Participation

3.1.1 How will participants be recruited?
(Detail all criteria to be used in selecting participants, including exclusion criteria)

Participants are selected based on their involvement in the formulation of health service policy, the implementation of this policy at senior management level, the management and delivery of the services affected by this policy, their involvement at a senior level in determining the development of the role of nurses and midwives in the delivery of these services.

It is possible to identify the following categories of relevant key stakeholders who could be considered subjects for the research to be conducted. These are as follows:

9) Policy Makers
10) Service Managers
11) Medical Consultants
12) Educators
13) Directors of the Nursing and Midwifery Planning and Development Units (NMPDUs)
14) Directors of Nursing and Midwifery

National strategy in nursing and midwifery will be driven principally by the members of these categories. For that reason they constitute the most important targets for the primary research to be conducted as part of this study.

Other important categories include –

15) Assistant Directors of Nursing
16) Clinical Nurse Managers (CNMs – grades 1, 2 and 3)
17) Specialist nurses (including Clinical Nurse / Midwife Specialists – CNS / CMS, and Advanced Nurse / Midwife Practitioners (ANP / AMP)
18) Staff Nurses / Midwives

For the purpose of defining institutions and individuals for inclusion in the sample to be used in the research, the following general criteria will be applied –

7) **Policy Makers** – It is possible to identify a core group of individuals in key posts involved in determining the shape of health services in the future and the role of nursing within those services. These include –
   a. Secretary General DoHC (DoHC);
   b. Assistant Secretary responsible for Strategy Implementation, DoHC;
   c. Head of Project Strategy Implementation, DoHC;
   d. Director of Personnel Section, DoHC;
   e. Chief Nurse, DoHC;
   f. Chief Medical Officer, DoHC;
   g. Principal Officer responsible for Nursing Policy Division, DoHC;
   h. Chief Pharmacist, DoHC;
   i. Principal Officer responsible for National Task Force on Medical Staffing, DoHC.

   n = 9

8) **Service Managers** – This category can be divided into two sub-groups:

a. **Group 1 –** A limited group of key **targeted individuals with overall accountability** for the implementation of policy, the reform of the services and the delivery of services –

i. Chief Executive of HSE;
ii. Head of Change Management Team within HSE;
iii. Two Members of Board of HSE (Nurse Representative and Author of Brennan Report);
iv. National Directors of HSE (3);
v. Director of HeBE;
vi. Health Board Chief Executives (11);
vii. Chief Executives of Major Academic Teaching Hospitals (12)
viii. Directors of Public Health (2).

In total this amounts to 33.

b. **Group 2 –** A wider group of **service managers with responsibility for the delivery of services** in specific geographic areas and care settings selected randomly from a stratified list. Institutions for inclusion on this stratified list will include representatives of acute and primary care settings where there is a significant nursing component. Out of a total population of approximately 400 for this category, a stratified random sample will be chosen of 10.

n = 43

9) **Medical Consultants** – Out of a total population of 1,731 Consultants in the country, the research will concentrate on those Consultants who were members of the National Taskforce on Medical Staffing and in clinical areas with nursing relevance.

n = 10

10) **NMPDUs –** There are 8 Directors of these Units in the country. All of them will be included in the research.

n = 8

11) **Educators –** It is possible to divide this category into three, each of which has historically developed in very different ways and reflects a different culture and professional emphasis –

a. **Group 1 –** Professors of Nursing and Heads of Schools of Nursing in Universities. The specific characteristics of this group is that not alone are they responsible for the delivery of essential services in the areas of pre-registration education, post-registration academic education and continuing professional development, but they are also expected to take a lead in the promotion and development of research in nursing. The size of this population is 7, however, in two institutions the role of Professor Nursing and Head of School has been divided, where, as a general rule, the former is responsible for the development of research and the latter is responsible for the delivery of educational services. In both these cases it would be important to interview each individual. Therefore the population and sample size in this case is 9.

b. **Group 2 –** Heads of Schools of Nursing in the Institutes of Technology, where the emphasis is on the delivery of pre and post-registration educational services. The total population size for this group is 7, all of whom will be included in the research.

c. **Group 3 –** Directors of the newly formed Centres for Nurse Education, located in the major teaching hospitals and with a specific role in the area of continuing professional development and development of links between education and clinical practice. The total population size for this group is 10, all of whom will be included in the research.

n = 26

12) **Directors of Nursing and Midwifery –** The total population size of this category is 268. A random weighted stratified sample will be chosen of 40 to be included in the primary research. The criteria for stratification and weighting will be Band, Geographic location and area of service delivery (Acute, Primary)
n = 40

Categories 1 to 6 constitute the principal group involved in the determination of the future role for nursing and midwifery in the Health Services. For that reason they will be the main target for primary research. For the additional categories (7 to 10) there exist a number of secondary research resources published in 2003 and 2004 that report on primary research conducted and that can serve as a basis for analysis of the issues from the perspective of these categories. It should be remembered in this context that the qualitative research data from the other categories will be collected during 2004 and early 2005.

For categories 1 to 4, and for category 5, Group 1, the principal instrument for data collection will be semi-structured interviews. For category 5 Groups 2 and 3, and for category 6 focus groups will be used. For categories 7 to 10 secondary research sources will be used.

This implies that a total of 76 semi-structured interviews will be conducted as part of this research broken down as follows –

6) Policy Makers – 9

7) Service Managers – 40

8) Medical Consultants – 10

9) NMPDUs – 8

10) Educators, Group 1 – 9

In addition, 9 focus groups will be held with 57 individuals, in distributed over four groups. The semi-structured interviews will be conducted face-to-face. A more detailed description of the instruments to be used and the approach to be adopted is provided in section 6 Research Instruments.

3.1.2 In order to access the target population is there a requirement for any other person(s) to be given details.

Yes [ ] No [No] If yes, please provide details of who and the information that will be given to the person (people)

3.1.3 How many participants will be included?

A total of 76 semi-structured face-to-face interviews will be conducted; focus groups will be held with an additional 57 in four groups.

3.1.3 Give a brief justification of your choice of sample size

There is a limited number of persons in the country who can influence the development and implementation of policy that affects the role of nursing and midwifery within the health services in Ireland. It is possible therefore to achieve a very wide coverage of the population involved.

In the case of sub groups within the chosen targets for research, random stratified sampling is used (e.g. in the case of category 2 Service Managers), using criteria such as geographic, demographic and area of health care being provided.

3.1.4b Give a brief justification of your choice of statistical analysis to be performed

The research is a qualitative study. Statistical analysis will not be performed. The principal steps in the data analysis will include the following –

1) The taped interviews and focus group discussions will be transcribed and coded using thematic content analysis.

2) Preliminary computer analysis of the data will be undertaken using a proprietary software package designed for qualitative data analysis (Ethnograph)

3) Particular attention will be paid to issues raised in all or most of the focus group discussions and the issues that were most discussed. This will result in the compilation of a list of the most frequently assigned codes.

4) The intensity of the discussion and views expressed on the issues raised will be analysed based on the list of most frequent codes.

5) In addition to computer-assisted analysis, further manual content analysis will be undertaken because of the complex nature of the data and of the concepts being researched.

6) The analysis of content and the coding of the data will facilitate the identification of themes within and across focus groups and individual interviews. This will provide the basis for the development of a thematic framework, showing the interrelationship between emerging themes.

3.1.5 Will the study knowingly involve participants and / or require consent from persons in any of the groups listed below?

	INVOLVEMENT		**CONSENT**	
	YES	**NO**	**YES**	**NO**
Participants for whom English is not a first language		**No**		

Children (< 16 years of age)		**No**		
People with intellectual disabilities		**No**		
People with a chronic mental health problem		**No**		
People experiencing an acute mental health problem		**No**		
Persons unconscious or severely physically ill		**No**		
Persons with communication difficulties		**No**		
Women of child-bearing potential		**No**		
Other groups who may be considered vulnerable (Please specify below)		**No**		

3.1.6 If you answered YES to any of the above, please describe for each group what specific strategies you propose putting in place to ensure that they are fully informed about the nature of their *involvement* and if *consen*t is required that it is truly informed consent?

Not applicable

3.1.7 If women of childbearing potential are to be involved, do the study design and the subject information sheet address the 9 essential points listed in the accompanying checklist?

YES	NO	N/A	**IF NO, PLEASE EXPLAIN WHY**
		N/A	

3.2 Consent

3.2.1 How will consent be obtained from the participants (verbal / written / visual)?
(Please attach a copy of letter, consent form, information leaflet etc.)

Participants will in the first instance be contacted by letter informing them of the purpose and objectives of the research and inviting them to take part on a voluntary basis. This letter will be followed up by a telephone call to arrange for their participation. At the time of the interview, participants will be asked to sign a consent form, indicating that they have taken part voluntarily and consent to the results being used in the analysis. A copy of the letter of invitation, an information leaflet and consent form is attached.

3.2.2 When will consent be obtained from the participants (and in what context)?

Initial consent will be obtained by telephone and subsequent written confirmation of consent will be obtained at the time of the interview / focus group discussion.

3.2.3 How long will the participants have to decide whether to take part in the study?
(It is recommended that a period of seven days be provided for reflection. If less than this, please justify)

Written invitations will be sent to participants one week before they are contacted by phone. This will provide them with ample time to reflect before written consent is obtained.

3.3 Confidentiality

3.3.1 How will confidentiality of participant identities be maintained throughout the study and after the study is completed with regard to data collected and patient / client records?

Participants will not be identified in the analysis of the results. Data will be aggregated, with numbers used to code transcripts.

3.3.2 Is there any potential confidentiality issue through identification of the study location?

No.

3.3.3 How will confidentiality of other information be maintained throughout and after the study is completed?

No information about individual participation will be divulged or identified in any way. At the start of the focus groups ground rules will be agreed requiring each individual participant to respect the confidentiality of the others. All transcripts will be coded with numbers.

3.3.4 Will the study data be held on a computer?

YES [Yes] NO [ ]

3.3.6 If you answered YES to question 3.3.4, how will you provide data protection?

All data will be stored in a manner that is compliant with the Data Protection Act. Data will be stored on CD. None of the data will be capable of being identified as coming from a particular individual. Coding of contributions and data blocks will be anonymous. Access to all files will be password protected and will be stored in a secure location. No data will be stored on servers that can be accessed by persons not involved in the research. The CDs will be stored in a private and secure location known only to the principal investigator.

3.3.7 Who else will have access to the study data other than the lead investigator?

The supervisor of the study. One clerical assistant.

3.3.8 What steps will you take to safeguard confidentiality of the study data accessed by this/these persons?

The data will not contain any identification of individual participants. A system of codes will be devised available only to the principal investigator. The supervisor and clerical assistant will be informed of a need of confidentiality and will be asked to sign a declaration agreeing to confidentiality of all aspects of the study.

3.3.9 How will study data / specimens be stored during and after the study?

Interviews will be taped, numbered and coded. Manuscripts will also be coded. The codes will be stored separately and accessed only by the lead investigator.

3.3.10 Are there elements of genetic testing involved in the proposed project?

YES	NO	N/A	**IF YES, PLEASE EXPLAIN**
	No		

3.3.11 How long after the study is completed will information / data / materials be retained?

Information, data and material will be stored for 7 years. This is in line with practice in the public sector – data within the National Council for example, is required to be stored for this period.

3.3.12 If identifiable data or material will be retained after the study is completed, is it stated on the informed consent form that this will be done and that material will not be used in future unrelated studies without further specific permission being obtained?

YES	NO	N/A	**IF NO, PLEASE EXPLAIN WHY**
Yes			

3.4 Other Ethical Rights

3.4.1. Outline in detail how you propose to uphold the ethical rights of the participants (self-determination, fair treatment, protection from harm and discomfort, privacy, etc.)?

For example, although conducting interviews is usually physically harmless, it may cause participants some psychological distress, if unwittingly the interview itself evokes some prior unpleasant experience for the person.

Participants will at all times be free to withdraw their consent without penalty. Interviews will be conducted in a sensitive manner and will deal only with the issues covered by the objectives of the research.

The researcher will at all times ensure that there is no pressure on the participants because of the role of the principal investigator (see section 2.5).

3.5 Funding and Payment

3.5.1 Outline sources of funding for the study.

The researcher has made provision for the funding of the study.

3.5.2 Is this study funded in a way that may produce a conflict of interest?

No.

3.5.3 Will payment be made to research participants?

Yes ☐ "None, other than minimal expenses to cover taxi fares etc". ☐ No ☒ No

3.5.4 If you answered YES to question 3.5.3, please specify for what purpose the payment will be made and the amount per participant.

N/A

3.6 Other Ethical Considerations

3.6.1 Please outline other ethical issues that you perceive to be associated with the study.

My role (see section 3.4.1 and 2.5)

3.6.2 Discuss how you will address each of the issues identified.

N/A

SECTION 4 – ETHICAL APPROVAL FROM OTHER COMMITTEES

Ethical approval from the Faculty Ethics Committee, if granted, does not supersede any requirements that outside bodies may have that similar applications be made to local ethical approval bodies in advance of the study commencing.

4.1 Has ethical approval been sought from any other organisation(s) in which the study will take place?

YES		(If you answer YES go to question 4.2)
NO		(If you answer NO go to question 4.3)
N/A	N/A	(If N/A please explain why below)

The study is not being carried out in any one institution. Individual participants take part in their own right and not as representatives of their institution.

4.2 If you have answered YES to question 4.1, has ethical approval been given?

YES	Awaiting Reply	NO	N/A	**IF NO OR N/A, PLEASE EXPLAIN WHY**

4.3 If you have answered NO to question 4.1, is it your intention to seek ethical approval from the organisation(s) in which the study will take place?

YES	NO	N/A	**IF NO OR N/A, PLEASE EXPLAIN WHY**

SECTION 5 – RISKS AND SAFEGUARDS

5.1 Give details of any risks to subjects or to controls from investigative procedures?

NOTE: for the protection of both the investigator and the subject, this list must be comprehensive and must also appear in full in the subject information leaflet.

Not applicable.

5.2 Indicate how adverse events are to be notified and evaluated:

Not applicable

5.3 What is the nature and extent of the medical examination that participants are to undergo before participating in this project?

None

5.4 Will there be ongoing medical supervision of the subjects by a duly insured medical practitioner during the study?

YES	NO	N/A	**IF NO OR N/A, PLEASE EXPLAIN WHY**
		N/A	There are no medical implications in this study.

5.5 What arrangements exist to guarantee compensation to any participant who may suffer injury or loss as a result of this project?

None – this is not applicable to this study.

SECTION 6 – DRUGS AND OTHER THERAPEUTIC SUBSTANCES:

6.1 Is the object of this project to assess the effect of a drug or therapeutic substance?

YES		(If you answer YES, a full application must be made for Clinical Trial approval to the Irish Medicines Board and this ethics approval should be directed to the St James' Hospital and Federated Dublin Voluntary Hospitals Joint Research Ethics Committee (JREC))
NO	No	

SECTION 7 - SIGNATURE OF APPLICANT

7.1: The lead investigator must sign that he or she:

- Affirms that the information in this application is true
- Is not aware of any other ethical issue not addressed within this form
- Understands the obligations to and the rights of the participants, particularly in giving of information and obtaining of consent, and confidentiality

I confirm that the information provided in this protocol is correct. I also undertake to provide an annual report on the anniversary of Research Ethics Committee approval with details of the number of subjects who have been recruited, the number who have completed the study and details of any adverse effects. Any serious adverse effects will be reported immediately to the Ethics Committee, and, if involving medication this will also be reported to the Irish Medicines Board.

NAME:(BLOCK CAPITALS)	**Yvonne O'Shea**		
STAFF / STUDENT I.D. No.			
SCHOOL / DEPARTMENT:	School of Nursing, Faculty of Health Sciences		
COURSE OF STUDY:(if appropriate)	PT Research Degree	**YEAR**	1
SIGNATURE:		**DATE:**	

Student applicants are <u>required</u> to have their Research Supervisor complete this section.

Name of Supervisor:
(BLOCK CAPITALS) Prof. Cecily Begley

Position: Head of School of Nursing

To the best of my knowledge this proposed research study is:

1	***Relevant***	**YES**	Yes
2	***Most appropriately investigated through the chosen design***	**YES**	Yes
3	***As the student's supervisor, I accept responsibility for the ethical conduct of this project***	**YES**	Yes
4	***I have had sufficient time to review this submission***	**YES**	Yes

Signature of the Supervisor:

Date:

Office Use Only:

Reference number	
Committee Date	

		Date
Approved	ڤ	
To be resubmitted	ڤ	

Appendix 22 – Themes, Categories, Codes

Themes	Categories		Code Description	Code
ED Educational Changes	**CD**	**Common Education**	Advantages	**EDCDAD**
			Content	**EDCDCO**
			Disadvantages	**EDCDDI**
			Financial Skills	**EDCDFS**
			Health Economics	**EDCDHE**
			Management	**EDCDMG**
			Team working	**EDCDTW**
	CP	**Continuing Professional Development (CPD)**	Evaluation of Effectiveness of CPD	**EDCPEV**
			Joint Appointments	**EDCPJA**
	PD	**Post-Registration Education**	Evaluation of effectiveness of post-registration	**EDPDEV**
	PR	**Pre-Registration Education**	Evaluation of effectiveness of pre-registration education	**EDPREV**
FH Future of Health Services	**AC**	**Changes in Accountability**	Accountability at all levels in the organisation	**FHACAL**
			Critical Incident follow-up (tribunals, complaints, mistakes, etc.)	**FHACCI**
			Clinicians in Management	**FHACCM**
			HSE Now accountable - not Minister	**FHACHS**
			Increased Audit	**FHACIA**
			Performance Management (tackling underperformance)	**FHACPM**
			Political scrutiny of expenditure of public money	**FHACPP**
			Value for Money / Inputs / Outputs / Outcomes	**FHACVF**
	CE	**Changes in Culture**	Culture Challenge	**FHCECC**
			Interdisciplinarity	**FHCEID**
			Relations with other professionals	**FHCEPR**
			Break down silos	**FHCESI**
			Team working	**FHCETW**
	DE	**Demographics**	Ageing	**FHDEAG**
			Family	**FHDEFA**
			Lifestyle	**FHDELI**
			Multiethnicity	**FHDEME**

Themes		Categories		Code Description	Code
		OS	**Changes in Organisational Structures**	Implications for Hospitals	**FHOSHO**
				Relations between Primary and Acute	**FHOSPA**
				Primary Care Services	**FHOSPC**
				Service Development	**FHOSSD**
		PE	**Separation of Policy and Executive**	Advantages of Policy Executive Separation	**FHPEAD**
				Centralisation of Executive	**FHPECE**
				Changes for Department of Health	**FHPEDH**
				Disadvantages of Policy Executive Separation	**FHPEDI**
		QU	**Quality**	Importance of Information	**FHQUIN**
				Patient Centred	**FHQUPC**
		SE	**Socio-economic Chantges**	Expectations	**FHSEEX**
				Wealth	**FHSEWE**
		SP	**Systems Pressure**	Increased activity levels	**FHSPAL**
				Private Services	**FHSPPR**
RC	**Role Change**	**AD**	**Adapt to Role change**	Career pathways	**RCADCW**
				General Management's understanding of change	**RCADGM**
				Proactive adaptation to change	**RCADPA**
				Prescribing as part of role change	**RCADPS**
				Preparedness for change	**RCADPX**
				Resistance to change	**RCADRX**
				Resistance to change by Trade Unions	**RCADTU**
				Understanding of change by nurses and midwives	**RCADUX**
		CN	**Commission on Nursing**	Evaluation of Commission on Nursing	**RCCNEV**
		CW	**Clinical Career Pathway**	Advanced Practitioner	**RCCWAP**
				Specialist Nurse Consultant Relationships	**RCCWCO**
				Dangers of specialisation	**RCCWDS**
				Need for more Specialist Nurses	**RCCWMS**
				Specialist Nurse NCHD Relationships	**RCCWNC**
				Staff Nurse Career Pathway	**RCCWSN**
		IT	**Interdisciplinary Teams**	Increased involvement in interdisciplinary teams	**RCITII**

Themes		Categories		Code Description	Code
		LE	**Leadership**	Assertiveness	**RCLEAS**
				Empowerment	**RCLEEM**
				Need for nurse leaders	**RCLENL**
		NL	**Nurse Led**	Coordinating Role of Nurses	**RCNLCR**
				Nurse led clinical services	**RCNLCS**
				Nurses in Management	**RCNLNM**
		PA	**Primary Acute Relations**	Acute nurses follow on into the community	**RCPAAC**
				Nurses in Community	**RCPANC**
SK	**Skills**	**SC**	**Current Skills**	Bellcurve	**SKSCBC**
				Do nurses have skills now?	**SKSCNN**
		SD	**Difference from now?**	Continuity with present	**SKSDCP**
				New skills needed	**SKSDSN**
		SF	**Future Skills Needed**	Communication	**SKSFCO**
				Financial Skills	**SKSFFS**
				Interdisciplinary skills	**SKSFID**
				Management	**SKSFMG**
				People Management	**SKSFPM**
				Research	**SKSFRE**
				Specialisation	**SKSFSP**
				Teamworking	**SKSFTW**
		SM	**Skill Mix**	Boundary spanning	**SKSMBS**
				Core job	**SKSMCJ**
				Health Care Assistants	**SKSMHA**
				Nurse Ratio	**SKSMNR**
				Recruitment issues	**SKSMRE**
				Total Number of Codes	**90**

Appendix 23 – Code Book from Ethnograph

	Code	Word	Parent	Text	Level	Added	Modified
2	ED		None		2	02/11/06	00/00/00

Refers to the questions about the educational system for nurses and midwives (Q 11 & 12)

3	CD		ED		3	02/11/06	10/04/07

Refers to the possibility of developing common education opportunities for clinical professionals from different disciplines

4	EDCDAD		CD	YES	4	02/11/06	28/05/07

Refers to the advantages of a common educational system

5	EDCDCO		CD	YES	4	02/11/06	28/05/07

Refers to the content of a common educational curriculum (27). Also includes instances of references to need for communications training (9).

6	EDCDDI		CD	YES	4	07/04/07	28/05/07

Refers to the disadvantages of a common educational system

7	EDCDFS		CD	YES	4	02/11/06	28/05/07

Refers to the desirability of providing clinical professionals with training / education in financial skills

8	EDCDHE		CD	YES	4	02/11/06	28/05/07

Refers to the desirability of providing clinical professionals with education / training in health economics

9	EDCDMG		CD	YES	4	02/11/06	28/05/07

Education for clinical professionals in administration systems

10	EDCDTW		CD	YES	4	02/11/06	28/05/07

Education / training for cllinical professionals in team working skills

11	CP		ED		3	02/11/06	09/04/07

Refers to matters arising under the heading of CPD

	Code Word	Parent	Text	Level	Added	Modified
12	EDCPEV	CP	YES	4	07/04/07	28/05/07

Refers to the need to evaluate the effectivenss or otherwise of CPD as a way of addressing skills deficiencies

13	EDCPJA	CP		4	09/09/07	00/00/00

There is a need to use more the opportunities to make joint clinical / educational appointments.

14	PD	ED		3	28/08/07	00/00/00

Refers to the provision of post registration education and training for nurses and midwives

15	EDPDEV	PD	Yes	4	28/08/07	28/08/07

There is a need to assess and evaluate the appropriateness of the provision of post registration training and education for nurses and midwives

16	PR	ED		3	22/12/06	00/00/00

Pre registration education

17	EDPREV	PR	YES	4	12/12/06	28/05/07

Evaluation of effectiveness of pre registration education

18	FH	None		2	02/11/06	00/00/00

Refers to the likely shape of future health services (Q2)

19	AC	FH		3	02/11/06	10/04/07

Future health services will be delivered in an environment where there will be significant increased emphasis on accountability

20	FHACAL	AC	YES	4	04/11/06	28/05/07

Ensure that accountability exists at all levels within the organisation from the CEO and Financial Director through all clinical grades (including clinical accountability) and administrative grades. Clinicians cannot be allowed to opt out.

	Code Word	Parent	Text	Level	Added	Modified
21	FHACCI	AC	YES	4	04/11/06	28/05/07

There is a need for more critical incident analysis with reference to the tribunals of enquiry, complaints, litigation, pressure groups etc. in order to ensure that lessons are being learned and changes made

22	FHACCM	AC	YES	4	02/11/06	28/05/07

Clinicians will be expected to become more involved in the management of the services and as a result will need to become more accountable for the services they provide

23	FHACHS	AC	YES	4	03/11/06	28/05/07

The CEO of the HSE is now accountable for the services - not the Minister

24	FHACIA	AC	YES	4	02/11/06	28/05/07

There will be an increase in the quantity and intensity of audit activity in future health services, examining issues of governance, value for money and accountability, and quality

25	FHACPM	AC	YES	4	04/11/06	28/05/07

Performance managemednt - tackling underperformance

26	FHACPP	AC		4	09/09/07	00/00/00

There will be a significant increase in the degree of political scrutiny of expenditure in health to ensure public accountability for the investment

27	FHACVF	AC	YES	4	02/11/06	28/05/07

There will be a greater emphasis on the need to demonstrate value for money in the provision of services, including accounting for inputs, outputs and outcomes

28	CE	FH		3	02/11/06	09/04/07

Changes in the future shape of health services will require a change in culture. New structures will result in the emergence of a new culture.

29	FHCECC	CE	YES	4	02/02/07	28/05/07

The future health services will present a significant cultural challenge

	Code Word	Parent	Text	Level	Added	Modified
30	FHCEID	CE	YES	4	02/11/06	28/05/07

The requirement for increase interdisciplinarity in service delivery requires the development of a new culture

31	FHCEPR	CE	YES	4	07/04/07	28/05/07

Refers to professional relationships as an important part of the cultural change needed for future health services

32	FHCESI	CE	YES	4	02/11/06	28/05/07

The demands of future health service delivery will require the breaking down of the silos in which professions have traditionally operated

33	FHCETW	CE	YES	4	02/11/06	28/05/07

The need for increased team working requires the creation and development of a new culture

34	DE	FH		3	02/11/06	10/04/07

Demographic changes will impact on future health service provision

35	FHDEAG	DE	YES	4	07/04/07	28/05/07

Future Health services will have to contend with the fact that our population will live longer and the population will be made up of more elderly who will require more services

36	FHDEFA	DE	YES	4	02/11/06	28/05/07

Future health services will have to contend with changes in the structure and nature of family life

37	FHDELI	DE	YES	4	02/11/06	28/05/07

Future health services will have to contend with changes in lifestyle and lifestyle related illnesses will become more prevalent

38	FHDEME	DE	YES	4	04/11/06	28/05/07

The multiethnic nature of Irish society will provide a significant change of context for future health services

	Code	Word	Parent	Text	Level	Added	Modified
39	OS		FH		3	02/11/06	00/00/00

The future health services will involve significant changes in organisational structures

40	FHOSHO		OS	YES	4	02/11/06	28/05/07

There are many implications for hospitals in the new health services including the role of independent hospitals, amalgamation of hospitals, the use of tertiary referral hospitals

41	FHOSPA		OS	YES	4	02/11/06	28/05/07

Future health services will require the definition of new relationships between primary and acute services

42	FHOSPC		OS	YES	4	02/11/06	28/05/07

Future health services will need to define the nature and extent of primary care service provision.

43	FHOSSD		OS	YES	4	12/12/06	28/05/07

Service development as an important part of changes in organisational structures in future health services

44	PE		FH		3	02/11/06	28/08/07

Future health services will be delivered in a context of separation of policy and executive functions

45	FHPEAD		PE	YES	4	02/11/06	28/05/07

Refers to the advantages of policy executive separation

46	FHPECE		PE	YES	4	02/11/06	28/05/07

Future health services will be delivered in a context of separation of policy and executive functions and a centralisation of executive functions in one body (the HSE)

47	FHPEDH		PE	YES	4	02/11/06	28/05/07

Future health services will entail significant changes in the role of the Department of Health - dedicated only to policy making

48	FHPEDI		PE	YES	4	04/11/06	28/05/07

The disadvantages of separation of policy and executive functions

	Code Word	Parent	Text	Level	Added	Modified
49	QU	FH		3	02/11/06	10/04/07

Future health services will be expected to place greater emphasis on quality

50	FHQUIN	QU	YES	4	02/11/06	28/05/07

Future health services will be delivered in a society with increased access to information and increased expectation of quality

51	FHQUPC	QU	YES	4	04/11/06	28/05/07

There will be an increased emphasis on putting the patient at the centre of service delivery and the monitoring of the patient's journey through a seamless service

52	SE	FH		3	02/11/06	10/04/07

Future health services will be delivered in a context of significant socio-economic changes

53	FHSEEX	SE	YES	4	02/11/06	28/05/07

Future health services will be delivered in a context where the public will have increased levels of expectation regarding the quantity and quality of services provided

54	FHSEWE	SE	YES	4	02/11/06	28/05/07

Future health services will be delivered in a society where increased wealth is the norm. Also refers to the correlation between health and wealth.

55	SP	FH		3	02/11/06	10/04/07

Systems pressure in future health services

56	FHSPAL	SP		4	09/09/07	00/00/00

Future health services will have to tackle the problem of increases in activity levels in areas such as A&E, an increase in the numbers of patients in both acute and community services, and a demand for an increase in the number of beds in acute services.

57	FHSPPR	SP	YES	4	02/11/06	28/05/07

Future health services are likely to include an increase in private provision of services. This may be as a result of political pressure or as a result of consumer choice and availability of new private services

58 RC	None		2	02/11/06	00/00/00

Refers to the likely changes in the roles of nurses and midwives in the future (Q3)

59 AD	RC		3	03/11/06	00/00/00

Adapt to role change

60 RCADCW	AD	YES	4	12/12/06	28/05/07

Career pathway as an important element of adapting to change in role changes for nurses and midwives

61 RCADGM	AD		4	09/09/07	00/00/00

Do general managers have a good understanding of the way in which the role of nurses and midwives will change?

62 RCADPA	AD	YES	4	03/11/06	28/05/07

Need to be proactive in adapting to role changes

63 RCADPS	AD	YES	4	12/12/06	09/09/07

There is a need for nurses and midwives to become involved in prescribing as part of the future role change for nurses and midwives.

64 RCADPX	AD		4	09/09/07	00/00/00

Are nurses and midwives prepared for the changes ahead?

65 RCADRX	AD		4	09/09/07	09/09/07

There is a problem of resistance to change within nursing and midwifery, particularly in relation to changes of role.

66 RCADTU	AD		4	09/09/07	00/00/00

There is a problem of resistance to change from within the Trades Unions that represent nursing and midwifery.

67 RCADUX	AD		4	09/09/07	00/00/00

Do nurse managers have a good understanding of the way the role of nurses and midwives will change?

68 CN	RC		3	09/04/07	00/00/00

Refers to the Commission on Nursing

Code Word	Parent	Text	Level	Added	Modified

	Code Word	Parent	Text	Level	Added	Modified
69	RCCNEV	CN	YES	4	31/01/07	28/05/07

Refers to the need to evaluate the impact of the Commission on Nursing 10 years after its implementation

70	CW	RC		3	09/04/07	00/00/00

Refers to the clinical career pathway for nurses and midwives and issues associated with it in the development and change of role for nurses and midwives

71	RCCWAP	CW	YES	4	02/02/07	28/05/07

Refers to the need for and the development of the role of advanced practitioner as part of the clinical career pathway for nurses and midwives. Also refers to the fact that advanced practitioners are an important dimension of specialisation and role change for nurses and midwives.

72	RCCWCO	CW	YES	4	02/11/06	28/05/07

Specialist nurses will need to develop new relationships with consultants

73	RCCWDS	CW	YES	4	02/11/06	28/05/07

Increased specialisation in nursing has some inherent disadvantages

74	RCCWMS	CW	YES	4	02/11/06	28/05/07

There is a need for more specialist nurses for future health services

75	RCCWNC	CW	YES	4	02/11/06	28/05/07

The existence of more specialist nurses will require an examination of the changes in the relationships with NCHDs

76	RCCWSN	CW	YES	4	07/04/07	28/05/07

Refers to the development of the role of the staff nurse within a clinical career pathway

77	IT	RC		3	02/11/06	09/04/07

Refers to the need for an increase in the use of interdisciplinary teams as a basis for service delivery

	Code Word	Parent	Text	Level	Added	Modified
78	RCITII	IT	YES	4	02/11/06	28/05/07

Increased involvement of nurswes and midwives in interdisciplinary work

79	LE	RC		3	02/11/06	00/00/00

Leadership is an important dimension to the changes in roles for nurses and midwives

80	RCLEAS	LE	YES	4	02/11/06	28/05/07

Nurses need to learn to be more assertive in their relationships with consultants and others within the services

81	RCLEEM	LE	YES	4	12/12/06	28/05/07

Empowerment as an important dimension of leadership in role change

82	RCLENL	LE	YES	4	02/11/06	28/05/07

There is a need for leaders to emerge within nursing and midwifery

83	NL	RC		3	02/11/06	00/00/00

Refers to an increase in the amount of nurse led services

84	RCNLCR	NL	YES	4	12/12/06	28/05/07

The coordinating role of nurses in nurse led clinical settings

85	RCNLCS	NL	YES	4	02/11/06	28/05/07

Refers to an increase in the amount of nurse led clinical services in future health services

86	RCNLNM	NL	YES	4	02/11/06	28/05/07

Refers to a range of issues related to the involvement of nurses in management, including the general management of services and the management of nursing and midiwfery

87	PA	RC		3	02/11/06	00/00/00

Refers to changes in the relationship between primary and acute services in the future

	Code Word	Parent	Text	Level	Added	Modified
88	RCPAAC	PA	YES	4	02/11/06	28/05/07

Nurses from acute services will be likely to get involved in follow through services to clients in the community on their discharge from the acute services

89	RCPANC	PA	YES	4	02/11/06	28/05/07

There is likely to an increase in the numbers of nurses and midwives active in the community

90	SK	None		2	02/11/06	00/00/00

Refers to issues related to the skills need for future health services (Q7, 8 & 9)

91	SC	SK		3	02/11/06	00/00/00

Refers to the question about whether nurses and midwives currently posess the necessary skills (Q9)

92	SKSCBC	SC	YES	4	02/11/06	28/05/07

Refers to the bellcurve phenomenon when looking at the distribution of skills across a group of professionals and the impact that a slight shift to the right by a number of individuals can have

93	SKSCNN	SC	YES	4	02/11/06	28/05/07

Do nurses and midwives have the necessary skills now (Q9)

94	SD	SK		3	02/11/06	00/00/00

Relates to the question about the difference between future skills require and current skills

95	SKSDCP	SD	YES	4	02/11/06	28/05/07

Refers to the dynamic nature of the organisational structures being developed and the fact that constant change will require constant ability to adapt to change and develop the relevant new skills - it is difficult therefore to say in what way the skills will be different - need for continuity with the present

96	SKSDSN	SD	YES	4	04/11/06	28/05/07

Refers to the skills needed in the future - also covered under role change and future skills needed (SKSF)

	Code Word	Parent	Text	Level	Added	Modified
97	SF	SK		3	02/11/06	00/00/00

Refers to the skills that will be needed in the future health services

98	SKSFCO	SF	YES	4	02/11/06	28/05/07

Refers to the need for greater communications skills for nurses and midwives in the future

99	SKSFFS	SF	YES	4	02/11/06	28/05/07

REfers to the need for greater understanding and training in financial skills for the health professionals of the future

100	SKSFID	SF	YES	4	12/12/06	28/05/07

Interdisciplinarity as an important dimension of future skills needed for nurses and midwives

101	SKSFMG	SF	YES	4	12/12/06	28/05/07

Management as an important skill of the future for nurses and midwives

102	SKSFPM	SF	YES	4	02/11/06	28/05/07

Refers to the need for greater people management skills by nurses and midwives for future health services

103	SKSFRE	SF	YES	4	02/11/06	28/05/07

REfers to the need for greater research skills in nurses and midwives in the future

104	SKSFSP	SF	YES	4	12/12/06	28/05/07

Specialisation as an important element of future skills needed

105	SKSFTW	SF	YES	4	12/12/06	28/05/07

Team working as an important element of future skills needed by nurses and midwives

106	SM	SK		3	02/11/06	00/00/00

Refers to a range of issues associated with skill mix

	Code Word	Parent	Text	Level	Added	Modified
107	SKSMBS	SM	YES	4	02/11/06	28/05/07

Refers to the phenomenon of boundary spanning as roles develop and scope of practice expands and extends

108	SKSMCJ	SM	YES	4	02/11/06	28/05/07

Refers to the problem of not being able to focus on the core job because of the need for professionals to be involved in administgrative duties and the opportunities presented by a more structured approach to skill mix to tackle this.

109	SKSMHA	SM	YES	4	02/11/06	28/05/07

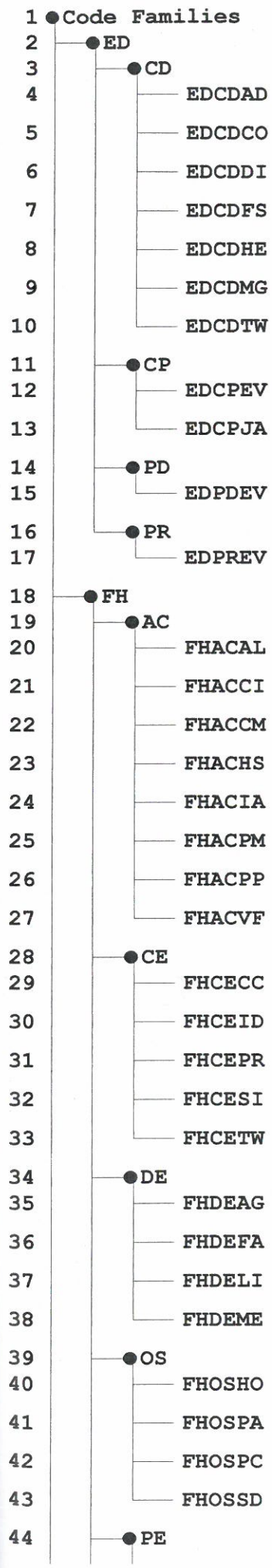
Refers to the need to train and utilise Health Care Assistants as part of the skill mix in the nursing and midwifery settings

110	SKSMNR	SM	YES	4	02/11/06	28/05/07

Refers to the overall ratio of nurses to patients in Ireland - contention that Ireland has the highest ratio among developed countries (check out...)

111	SKSMRE	SM	YES	4	02/11/06	28/05/07

Refers to recruitment and retention issues facing nursing and midwifery and in particular the need to rely on nurses from other countries (India, Phillipines ...)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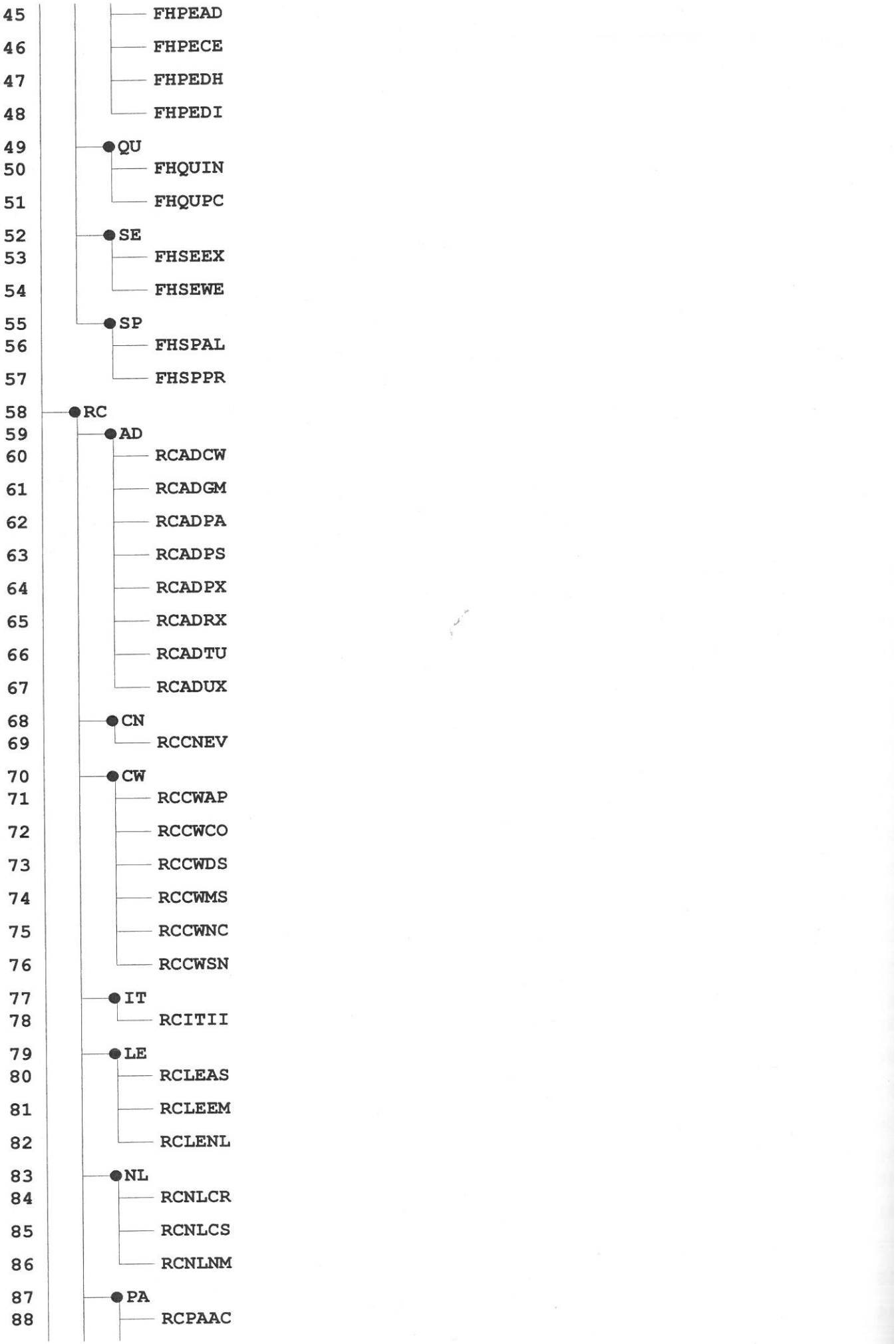
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69 RCCNEV
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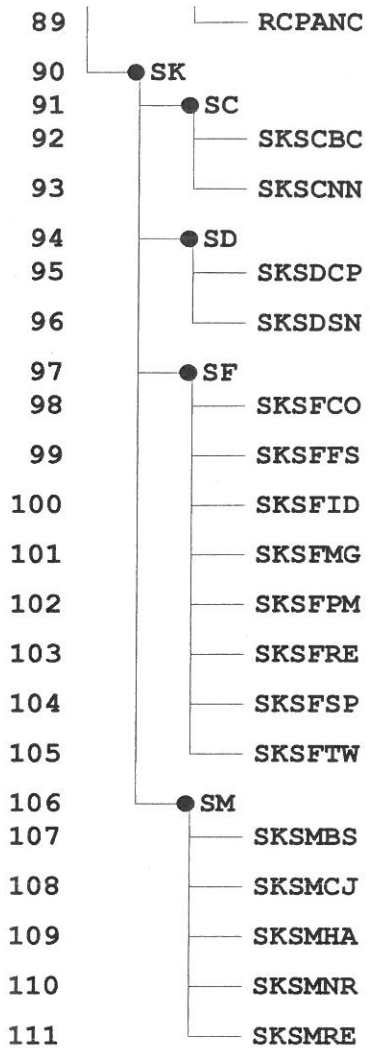
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101 SKSFMG
102 SKSFPM
103 SKSFRE
104 SKSFSP
105 SKSFTW
106 SM
107 SKSMBS
108 SKSMCJ
109 SKSMHA
110 SKSMNR
111 SKSMRE

Appendix 24 – Sample Extract Transcript from Interview

04070800

YOS	In relation to the major contextual changes for the Health Services, what do you think are the major ones in relation to the services themselves?	
RSP	I will be quite straightforward and simple on this. The changing economic and socio-environment, by that I presume we mean the fact that as time goes on, we will have more and more patients coming into the system and this is as a result of a number of factors, one is the ageing population, people living longer and people are being cured of their illness throughout their life with advances in medical technology, etc. We certainly are going to have more patients looking for hospital services. That is the generalised answer. The future direction of policy, I think myself, has to be geared towards ensuring that the beds are there for the patients. At the moment there is a shortage of beds within the system and that is in two areas, number one is the step-down facilities out there, and the community services have to be bolstered up. We need more acute beds within the system and you will find that any economic bench-marking that is done would clearly indicate that we have less beds per population than most other countries in the developed world. I am not going to talk about spend and health because that can be measured in many different ways. I am not a hundred per cent certain that the new health reforms are actually focused on that particular issue. It seems to be all about structure. There is a view that the money has been misspent and that the money has not been utilised for more effectively for the patients, so really I think that the health reform programme has taken the government's eye off the ball in respect of what the main issues are. I do not think that by creating a National Hospital's Office, while there are advantages in that, no way is that going to resolve the underlying problem that exists. On Hanly, again there are a lot of things you could probably do that would improve the situation marginally. At the same time the overall problem is the lack of beds. I think we can all make our hospitals more efficient and we are working on that at the moment but that will only solve the situation marginally. So, economic policy, future direction policy has to be geared towards making sure that the bed stock in the country is up to International norms.	
YOS	Do you have anything to say in relation to funding?	
RSP	We are constantly under pressure in relation to funding but I think you will find that every health service in the world is under pressure in relation to funding and that is something that really goes with the territory because obviously there is not a bottomless pit to provide funding for the health service. If you did that the country would be broke. I think that maybe different methods of allocating funding could be looked at. There could be improvements on the present system. There is a constant cry from	

	the Government that no matter how much money they put into the health sector, they still have problems. They speak about huge increases in expenditure over the last ten years or whatever. That is all true but I think that what is forgotten is that a lot of that increase has not gone towards the development of services or for the provision of new beds but has been spent on inflation, on keeping up with technology and massive salary increases which have had to be absorbed into the system. For instance, the nurse's deal of (I think it was the year 2000) put an increase of 25% on the health bill of the country. In my opinion there was no extra productivity arising in that at all. Probably, a catch up situation and that was followed by increases for other areas. Then you have the junior doctors getting all their funding for their overtime. Also, one that is quite forgotten is the cost of introducing the nursing diploma course, which cost quite a lot of money to the health service in that in the past the service was run by student nurses and now you had a new environment in which you needed qualified nurses to run the service. The DATHS have done exercises where we have proven that the actual real increase in funding made available is quite small. At the same time, all the academic teaching hospitals have significantly increased their throughput of work, while at the same time the increase in expenditure in real terms has not matched that. I think it is generally considered that the hospitals are quite efficient in the amount of work that they are putting through. You come in today at the fringes of a very difficult meeting with our Union about our A&E situation. That is symptomatic of all the issues that I have spoken to you about. The issue is that there are far too many patients in our A&E Department. You go round the wards in the hospital here and everybody is under pressure. Do you want me to talk about political impacts?	
YOS	Yes, the relevance of them?	
RSP	I have watched very closely, the way the political side of it responds to these issues. I think there are various aspects of the political situation in the present Government. You have a very strong progressive democrat axis supported by Charlie McGreevy, which is taking a very hard line on the health service. He is particularly concerned with reducing numbers employed within the health service and has imposed the staff ceiling, which has made it extremely difficult to actually manage the hospitals. The staff ceiling has been a very blunt instrument, which is causing absolute havoc with the system. Politically you have the DATHS axis, then you have those ministries which are concerned with social issues and I think that there is an internal battle going on within Government on that one. There is a view on the Progressive Democrat's side that there should be a more leaning towards using more private medicine, private facilities and that the public sector should be availing of those facilities. I think that it is true to say that some of those policies have been working and I have to reluctantly admit that the National Treatment Purchase Fund is a good concept in that it ensures that patients who need minor	

Appendix 25 – Sample Extracts from a Coded Interview

+Interview 4, 04071200

Note: Throughout the transcript, the interviewer is identified by YOS; the interviewee as I004.

YOS: First question in relation to the major contextual change for our health services of the future. Highlighted a number of areas that you may be able to talk about for example the changing socio-economic environment, future direction of policy, economic and political impacts and social changes……or anything else that you might feel is relevant

I004: I think all of those are relevant in care in the environment which

#-FHSEEX

operates including the environment in which all these professionals currently practice and how they practice and the expectations then that the public have from all the professions in regard to what they expect to receive from them. It's also from, what I can see, a trend which isn't just happening here its happening in the UK where it is going on in a very structured way. It hasn't started very effectively here at the moment but in a way we are not the trend setters we follow the trend to a great extent.

YOS: How would you describe the most likely future of our Irish health services….9 areas there that you may want to pick up on, including separation of policy and executive functions, changing structures, delivery mechanism the whole accountability and culture and role and size and epidemiology

#-FHACAL

I004: It's not just in health the question of accountability is coming to the core. This whole situation…in our context of corporate governance is now very important and who is responsible for what and how the authority is responsible for what they are doing so it's not unique to

#-FHACCI #-FHACAL #-FHCECC

Ireland that that is happening. I see certain incidences in that it happened in the UK as well, where corporate governance and accountability is very important the changes of culture, changes of role is one which people seem to be homing in on to a great extent. I suppose in a way I would a bit worry about take for example the professions as we know them they all have a very important role it's a perceived role and an accepted role and you cannot change a role overnight it has to be accepted on all sides.

YOS: The role of nurses and midwives and again do you think this will change significantly over the next 10 years and again I have 10 indicators of areas that might be effected……such as (YOS reads them out)

I004: It seems to me that all of those are changing even as we speak. Over the past number of years we have nurse managers and we have them in hospitals whether their role will vary to that extent outside hospitals I don't know that's something that is there because there are an awful lot of other professionals out there operating in

#-RCADPS

the community that would have to be satisfied in regard to increasing the role of nursing for example in the prescribing area, that's not an easy area. In some countries what they have lists on which they can operate and that is probably the way I can see things evolving here would be on the basis of lists rather than giving a nurse an entitlement to everything. I heard this morning about this morning after pill where even pharmacists can supply it in certain circumstances and that's of course is an anomaly and people can build on anomalies too increase a role where it was not intended at all. So it's inevitable that there will be great changes on every heading there but in some areas it will be more than others.

YOS: In relation to prescribing…would you see this evolving for nurses, and through protocols?

I004: Yes

YOS: I know you mentioned lists like they have in UK

#-RCADPS

I004: That's right yes I think it would be a mixture of protocols and lists because medicine today is exceptionally complex and really to prescribing of a drug should follow diagnosis or clinical examination and there is an expectation of that in prescribing so in other words it is also the bio chemical picture which is taken into account across the board as well its doubtful whether even any one profession would be able to prescribe confidentially and certainly not the widen range of drugs out there without some form of a list coupled with protocols is the way to go and that in fact will probably be the way they will be able to in the short term to medium term that will happen actually the ….. …… is one that is desirable.

Appendix 26 – Member Checking Questionnaire

The Future of Health Services in Ireland

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Future health services will be delivered in a context of significant socio-economic changes. (SE)				
The public will have increased levels of expectation regarding the quality and quantity of services provided. (FHSEEX)				
Future health services will be delivered in a society where increased wealth is the norm. Public expectations will increasingly establish a correlation between health and wealth. (FHSEWE)				
Demographic changes will impact on future health service provision. (DE)				
Future health services will have to contend with the fact that our population will live longer and the population will be made up of more elderly people who will require more services. (FHDEAG)				
Future health services will have to contend with changes in the structure and nature of family life. (FHDEFA)				
Future health services will have to contend with changes in lifestyle and lifestyle related illnesses will become more prevalent. (FHDELI)				
The multiethnic nature of Irish society will provide a significant change of context for future health services. (FHDEME)				
Future health services will be delivered in a context of separation of policy and executive functions. (PE)				
There are advantages associated with the separation of policy and executive functions. (FHPEAD)				
There are disadvantages associated with the separation of policy and executive functions. (FHPEDI)				
The separation of policy and executive functions will also be accompanied by a centralisation of executive functions in one body – the HSE. (FHPECE)				

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Future health services will be delivered in a context where the role of the Department of Health will change significantly – dedicated only to policy making. (FHPEDH)				
Future health service delivery will entail significant changes in organisational structures. (OS)				
There are many implications for hospitals in the new health services including the role of independent hospitals, the amalgamation of hospitals, the use of tertiary referral hospitals. (FHOSHO)				
Future health services will require the definition of new relationships between primary and acute services. (FHOSPA)				
Future health services will need to define the nature and extent of primary care service provision. (FHOSPC)				
Service development will be an important part of changes in organisational structures in future health services. (FHOSSD)				
There will be significant pressure on all systems within the future health services. (SP)				
Future health services will have to tackle the pressure of overcrowding in the A&E services. (FHSPAE)				
Future health services will have to tackle the problem of bed numbers. (FHSPBN)				
Future health services will have to tackle with the problem of medical inflation which requires additional funding in areas other than bed numbers. (FHSPMI)				
Future health services will have to contend with increase numbers of patients in acute and community services. (FHSPMP)				
Future health services will have to deal with the problem of staff numbers in the context of ceilings imposed by policy makers. (FHSPSN)				
Future health services will have to deal with the fact that politicians will be under increased pressure from their constituents and there is likely to an increase in the level of political scrutiny of services. (FHSPPP)				
Future health services are likely to include an increase in private provision of services. This may be as a result of political				

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
pressure or as a result of consumer choice and availability of new private services. (FHSPPR)				
Future health services will be delivered in an environment where there is a significantly increased emphasis on accountability. (AC)				
The CEO of the HSE is now accountable for the services – not the Minister. (FHACHS)				
It will be necessary to ensure that accountability exists at all levels with the organisation, from the CEO and Finance Director through all clinical grades (including clinical accountability) and administrative grades. Clinicians cannot be allowed to opt out. (FHACAL)				
Clinicians will be expected to become more involved in the management of the services and as a result will need to become more accountable for the services they provide. (FHACCM)				
There will be an increase in the quantity and intensity of audit activity in future health services, examining issues of governance, value for money, accountability and quality. (FHACIA)				
Performance management will become increasingly important, managing and tackling underperformance. ((FHACPM)				
There will be a greater emphasis on the need to demonstrate value for money in the provision of services, including accounting for inputs, outputs and outcomes. (FHACVF)				
There will be a need for more critical incident analysis with reference to the tribunals of enquiry, complaints, litigation, pressure groups, in order to ensure that lessons are being learned and changes made. (FHACCI				
Future health services will be expected to place greater emphasis on quality. (QU)				
Future health services will be delivered in a society where clients' expectations will increase in relation to the quality of care. (FHQUEX)				
There will be an increased emphasis on putting the patient at the centre of service development and delivery and the monitoring of the patient's journey through a seamless service. (FHQUPC				

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Future health services will be delivered in a society with increased access to information and increased expectation of quality. (FHQUIN)				
Future health services will generate a greater need for accurate and precise information. (FHQUNI)				
Information technology will become increasingly important in the generation of information and quality assurance in future health services. (FHQUIT)				
Future health services will be driven by increased emphasis on research – this will provide the basis for the development of more quality services. (FHQUMR)				
Changes in the future shape of health services will require a change in culture. New structures will result in the emergence of a new culture. (CE)				
The future health services will present a significant cultural challenge. (FHCECC)				
The requirement for increased interdisciplinarity in service delivery requires the development of a new culture. (FHCEID)				
The need for increased team working requires the creation and development of a new culture. (FHCETW)				
The relationship between the professions is an important part of the cultural change need for future health services. (FHCEPR)				
The demands of future health service delivery will require the breaking down of the silos in which professions have traditionally operated. (FHCESI)				

The Changing Role of Nursing and Midwifery in Ireland

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
The Commission on Nursing has had a major impact on the development of the role of nurses and midwives. (CN)				
The introduction of a new clinical career pathway for nurses and midwives brings with it significant developments in and change of the role of nurses and midwives. (CW)				

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
There is a need for more specialist nurses in future health services. (RCCWMS)				
Increased specialisation in nursing has some inherent disadvantages. (RCCWDS)				
The existence of more specialist nurses and midwives will require an examination of the changes in the relationships with NCHDs. (RCCWNC)				
There will be an increased involvement of nurses and midwives in interdisciplinary teams. (RCITII)				
It is important that the coordinating role of nurses and midwives in clinical settings is understood and appreciated more. (RCNLCR)				
There will be an increased involvement of nurses and midwives in management, including the general management of services and the management of nursing and midwifery. (RCNLNM)				
Nurses from acute services will most likely get involved in follow-through services to clients in the community on their discharge from the acute services. (RCPAAC)				
Nurses and midwives will be involved in the prescribing of medications. (PS)				
Leadership is an important dimension of the changes in roles for nurses and midwives. (LE)				
Empowerment is an important dimension in role change. (RCLEEM)				
Nurses and midwives need to adapt to role change. (AD)				
Nurses and midwives need to be proactive in adapting to role changes. (RCADPA)				
Nurses and midwives are prepared for the changes ahead (RCPXNP)				
Nurses and midwives are not prepared for the changes ahead (RCPXNP)				

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
It is important to identify resistance to change within nursing and midwifery and deal with it appropriately. (RCRXNM)				
The level of understanding of the way in which the role of nurses and midwives will change varies greatly. (UX)				
Nurse managers have a good understanding of the way the role of nurses and midwives will change. (RCRXNM)				
Nurse managers do not have a good understanding of the way the role of nurses and midwives will change. (RCRXNM)				
There is a need to evaluate the impact of the Commission on Nursing as we approach the 10th anniversary of its publication. (RCCNEV)				
It is important to provide staff nurses and staff midwives with access to a meaningful clinical career pathway. (RCCWSN)				
ANPs and AMPs are an important dimension of specialisation and role change for nurses and midwives. (RCCWAP)				
Specialist nurses will need to develop new relationships with consultants. (RCCWCO)				
Future health service delivery will require the creation of more interdisciplinary teams. (IT)				
There will be an increase in the amount of nurse led services. (NL)				
There will be an increase in the amount of nurse led clinical services. (RCNLCS)				
Future health services will see a change in the relationships between primary and acute services and this will impact on the role of nurses and midwives. (PA)				
There is likely to be an increase in the numbers of nurses and midwives active in the community. (RCPANC)				
There is a need for nurses and midwives to become involved in prescribing as part of the future role change for nurses and midwives. (RCPSNF)				
There is a great need for leaders to emerge from within nursing and midwifery. (RCLENL)				
Nurses need to learn to be more assertive in their relationships with consultants and others within the services. (RCLEAS)				

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
The clinical career pathway is an important element of adapting to change in role changes for nurses and midwives. (RCADCW)				
Nurses and midwives are adequately prepared for change? (PX)				
Nurses and midwives are not adequately prepared for change? (PX)				
There is a problem of resistance to change within nursing and midwifery, particularly in relation to changes of role. (RX)				
There is a problem of resistance to change from within the Trade Unions that represent nursing and midwifery. (RCRXTU)				
General managers have a good understanding of the way in which the role of nurses and midwives will change. (RCUXGM)				
General managers do not have a good understanding of the way in which the role of nurses and midwives will change. (RCUXGM)				

Building Skills and Competencies in Nursing and Midwifery to meet Future Challenges

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Nurses and midwives currently possess the necessary skills to face the future challenges of a changing health service. (SC)				
Nurses and midwives do not currently possess the necessary skills to face the future challenges of a changing health service. (SC)				
A change in the skill levels of a small number of nurses and midwives can have a significant impact on the quality of care provided in a clinical setting. (SKSCBC)				
There is a difference between the levels of skills required now and those that will be required in the future. (SD)				
There is a need for continuity with the present coupled with the ability to prepare for and adapt to change. (SKSDCP)				
Nurses and midwives will need communications skills in the future. (SKSFCO)				

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Nurses and midwives will need greater understanding of and training in financial skills for health care professionals in the future. (SKSFFS)				
The ability to work in an interdisciplinary environment will be an important dimension of the future skills required of nurses and midwives. (SKSFID)				
Management skills will be very important for nurses and midwives in the future. (SKSFMG)				
People management skills will be very important for nurses and midwives in the future. (SKSFPM)				
Nurses and midwives will need more highly developed research skills in the future. (SKSFRE)				
Nurses and midwives will be more specialised in future health services. (SKSFSP)				
It will be necessary to ensure that the appropriate skill mix in health care environments is achieved in the future. (SM)				
As the scope of nursing and midwifery practice expands, nurses and midwives will require the skill to span the boundaries between professions. (SKSMBS)				
There is a need to a more structured approach to skill mix within the clinical setting and to ensure that professionals are freed up to concentrate on their core job rather than caught up in a lot of administrative duties. (SKSMCJ)				
There will be a need to train and utilise to the full health care assistants as part of the skill mix in the nursing and midwifery settings. (SKSMHA)				
It is important to monitor the overall ratio of nurses and midwives to patients in Ireland. (SKSMNR)				
Ireland already has a high ratio of nurses and midwives to patients. (SKSMNR)				
There will continue to be significant retention and recruitment issues in nursing and midwifery in Ireland and the resultant need to rely on nurses from other countries (INDIA, Philippines …). (SKSMRE)				
There are advantages associated with the development of common education opportunities for clinical professionals from different disciplines. (EDCDAD)				

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
There are disadvantages associated with the development of common educational opportunities for clinical professionals from different disciplines (EDCDDI)				
Common training in communication skills should be included as part of a common education curriculum. (EDCDCO)				
Training in financial skills should be included as part of a common education curriculum. (EDCDFS)				
A general introduction to health economics should be included as part of a common education curriculum. (EDCDHE)				
Training in management and administration systems should be included as part of a common education curriculum. (EDCDMG)				
A common education curriculum should include training in team working skills. (EDCDTW)				
Nurses and midwives require access to a comprehensive programme of continuing professional development (EDCPEV)				
There is a need to evaluate the effectiveness or otherwise of CPD as a way of addressing skills deficiencies in nurses and midwives. (EDCPEV)				
More use should be made of the opportunities to make joint appointments between academic and practice settings. (EDJACE)				
There is a need to evaluate the effectiveness of the pre-registration education for nurses and midwives. (EDPREV)				

Appendix 27 – Letter to Participants in Member Checking

6th June 2007

Dear ,

I am in the process of writing up the results of the primary research I undertook as part of my PhD thesis. You will remember that you were good enough to take part in this research by allowing me to interview you. The theme of the research is *An Examination of the Strategic Challenges Facing Nursing and Midwifery in a Changing Health Service*.

I am attaching a paper that contains some statements that represent the key outcomes of the primary research. I would be very grateful if you would take the time to read the statements and to indicate whether you agree or disagree with them. By ticking the relevant column, you will be indicating that you either strongly agree, agree, disagree or strongly disagree with the statement. By indicating that you agree or strongly agree with the statement, I will take that to mean that you consider the statement to be a credible position to take, not that it is a position that you yourself would necessarily espouse. By indicating that you disagree or strongly disagree with the statement, I will take that to mean that you do not consider the statement to be a credible position to take.

Your cooperation in this exercise would be greatly appreciated. It will help me to check the quality and relevance of the outcomes of the research. For your convenience, I am enclosing a stamped address envelope for the purposes of returning the questionnaire.

Once again, I would like to thank you for your assistance to date. I will be happy to share with you the final outcomes of the research when they are available.

Yours sincerely,

Yvonne O'Shea.