

**A report to the National Co-ordinating Centre for NHS Service Delivery and
Organisation R & D (NCCSDO) of a scoping exercise on
“The contribution of nurse, midwife and health visitor entrepreneurs to
patient choice”**

(NM96)

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Executive summary

1. Introduction and Methods: This scoping exercise had the following aims. To:

- Develop definitions of nurse midwife and health visitor (NMHV) entrepreneurship in relation to current definitions of patient choice,
- Map the range and types of entrepreneurial NMHV activity across primary, secondary and tertiary health and social care provision in the state and independently provided sectors in the UK
- Conduct a review of available international published and grey literature concerning models of entrepreneurship in healthcare and related fields, of NMHV activity within this, and of policy initiatives in this area
- Analyse the extent of the evidence at a policy and local delivery level of both drivers and inhibitors of entrepreneurial activity by NMHVs, in particular related to the patient choice agenda and current NHS policy concerning contractual freedoms
- Using these sources, identify any design and delivery issues relevant to NMHV entrepreneurship that may promote better outcomes including choice for patients, carers, and their families
- Identify gaps in current knowledge and elaborate key research questions in order to inform future SDO calls for Proposals.

There were five elements to our scoping:

1. Exploring understandings of the use of the terms entrepreneur and entrepreneurial
2. A review of published and grey literature for NMHV entrepreneurial activity
3. Expert seminars with NMHV entrepreneurs and those responsible for commissioning such services or making policy with relevance to them
4. Policy mapping and analysis for relevant policy over a 10 year period including policy concerning patient choice
5. Synthesis of evidence and identification of gaps in knowledge and questions for further research

2. Setting the entrepreneurial scene

One seminal definition of an entrepreneur is 'one who shifts economic resources out of an area of lower and into an area of higher productivity and greater yield'. The mid-1980s saw the introduction of the term 'intrapreneur' to describe an employee who behaves 'entrepreneurially' within a corporation. The term 'social entrepreneur' has developed to describe those individuals who apply the same enterprise and imagination to social problems as commercial entrepreneurs apply to wealth creation.

Social entrepreneurialism has been seen as an appropriate model for also developing NMHV entrepreneurial activity. The term has been taken up by the UK government as part of its programme of addressing social inequality. One of the criticisms of much of the entrepreneur literature is that it has focussed on men involved in activities associated with financial gain, rather than social objectives. This does not reflect either the purpose or gender profile of nursing in the UK where 89% of registered NMHVs are female. Women are increasingly engaging in entrepreneurial activity globally and tend to report different drivers and barriers to becoming entrepreneurs to men.

3. The policy context

Government policy has attempted to promote aspects of entrepreneurial behaviour as one element of its approach to addressing social problems such as inequality and exclusion and to add flexibility to some health and social services traditionally delivered by state agencies. Health policy, since 1997 has featured 'modernisation' and, increasingly, patient choice. Some policy documents such as *The NHS Plan* (July 2000) and *Making a Difference strengthening the Nursing, Midwifery & Health Visiting contribution to health and healthcare* (1999) set out changes that are said to 'put nurses at the heart of the modernisation agenda' and later messages have explicitly urged them to become 'entrepreneurs' though the examples given of such entrepreneurial behaviour are limited and often are medical role substitution. The term has been used loosely. Successive changes to commissioning in the primary care sector have encouraged a wider range of providers. This has opened up the possibility, and the reality in a very small number of cases, for services to be provided by nurse-owned or led enterprises.

4. Nurses, Midwives, Health Visitors and Entrepreneurship: the evidence

There is very little research literature on NMHV entrepreneurial and personal, 'heroic' and journalist-written accounts dominate. Of 462 articles initially identified from our electronic and hand searchers, 143 met the inclusion criteria of relevance to the scoping. A total of 104 published papers described UK entrepreneurial activity among NMHVs. Beyond this was an additional grey literature e.g. we found 119 articles dealing with UK entrepreneurial activity among NMHVs in primary care settings alone. The International Council of Nursing estimates that in general 0.5-1% of registered practicing nurses, are nurse entrepreneurs. The following typology was developed from the literature:

1. The NMHV entrepreneurial employees (intrapreneurs): NMHVs in quasi-autonomous public health roles; NMHVs in clinical specialist roles
2. Employers/self employed providers of services with an indirect relationship to healthcare: Nurse consultancies; Infrastructure and workforce providers; Inventors /manufacturers
3. Employers/self employed providers of direct healthcare services: Mainstream health services delivered through the NHS; NMHV services offered directly to clients; Other health related services provided by NMHV directly to a client; Accommodation with nursing and health related services provided by N M HV proprietors

5. Findings from the expert seminars

Some 18 people attended the seminars which revealed information not apparent from the literature and these points are incorporated in our summary of findings:

6. Summary of findings

Although we found a range of NMHV entrepreneurial activity in the UK, it represents only a very small proportion of NMHVs and former NMHVs engaged in these types of activities. In this it reflects most of the international literature.

There is only modest agreement over the meaning of the term 'entrepreneur' in business and management literature. This does not help an understanding of the term 'nurse entrepreneur'. In some UK policy articulations, the term 'nurse entrepreneur' is used loosely, is ideological and actual examples given are often more accurately described as organisational flexibility or nurse substitution for medical roles.

The international literature on nurses entrepreneurs uses the term interchangeably with enterprise in some countries or uses completely different terms to describe self employed nurses and midwives or business owners (see chapter 2 and 4).

The scoping took a broad view of definitions in order to include rather than exclude activity (chapters 1 and 2). However, it was noted that there were challenges in dealing with the overlap with literature on innovation and change (chapters 1 and 4).

The UK scoping was analysed by type of activity (chapter 4, section 4.4). It was noted that certain groups of NMHVs, such as those with public health roles or some clinical specialist roles, are more likely to be intrapreneurial. Entrepreneurial NMHV

activities were identified that indirectly contributed to health care such as knowledge transfer through training and consultancy, invention of healthcare products, and provision of infrastructure services to health care and self-employed and small business provision of direct healthcare services (chapter 4 section 4.4.4).

Some recent policy changes in commissioning in the NHS primary care sector and the creation of a supply side market through encouraging 'third sector' health and social care enterprise make new forms of NMHV entrepreneurial and business activity possible. Chapter 4 documents the limited extent of this type of activity by NMHVs at present, although in a rapidly changing policy and policy implementation environment there is potential for this picture to shift. It is not clear to what extent NMHVs will move from being employees of the NHS or general practice to being nascent entrepreneurs as employers in new types of social enterprise business or as business partners in general practice. Nor is it clear how nascent NMHV entrepreneurs will fare in competing for contracts in environments where many more entrepreneurs and businesses are established compared with large corporations who are becoming involved in tendering for this new business opportunity.

It is noteworthy that many NMHV entrepreneurs had close relationships with the NHS. For some this was the source of their business, while others reverted to temporary employment when income levels dropped, moving out again because of dissatisfaction with the constraints of the NHS, and moving back in when self-employment was precarious.

We are uncertain whether increased levels of NMHV entrepreneurial activity are likely in the future. The expert seminars tended to indicate that those NMHV that have left the NHS to set up in business on their own, in a largely hostile and unfavourable climate, are atypical of the greater NMHV workforce as a whole. As these are classic characteristics associated with entrepreneurs this may be unsurprising, but their atypicality raises questions about the likelihood of increased numbers of NMHVs behaving entrepreneurially in this sector, which future research would need to explore.

The connection between NMHV entrepreneurial activity and patient choice appears not to be strong (chapter 4 section 4.6) with the possible exception of independent midwifery. Increasing patient choice was stated as an aspiration in 20% of the documents we analysed. Aspirations concerning autonomy of practice and professional accomplishment were cited in approximately 55% of these documents.

Financial motivations are not prominent in the literature but our seminar participants suggested this may be misleading because, they believed, talk of the profit motive is unacceptable within NMHV culture. The documented aspirations of the sample of intrapreneurial NMHVs were focused on addressing issues of equity in provision and access for those poorly served by current arrangements.

There is very little actual measurement (and therefore evidence) of the outcomes of entrepreneurial activity (chapter 4 section 4.6.1). If entrepreneurialism is an area to be encouraged, good process and outcome evaluations are needed to find out what works.

The theme of choice has a longer history in midwifery, with policy in the early 1990s encouraging choice for women in childbirth. However that increased choice is confined to a small number of clients, geographical access is restricted and currently user fees allow choice only for those who can afford to pay.

Both the literature and our expert seminars revealed some of the obstacles to becoming entrepreneurial, and surviving successfully in those roles e.g. the importance of the wider context – the NHS in general and in its present state of flux, and the wider professional environment – both NMHV socialisation and NMHV work takes place within the power structures of the health sector overall. If the NHS itself changes (e.g. becomes less secure and supportive), then the balance of risk/safety, cost/benefit of staying in it versus leaving to be an entrepreneur will also change.

Definitions of terms and assumptions

Patient	Any member of the population receiving care
Patient choice	We adopt a broad understanding to include choice over how to access healthcare services, where to access them and which type of worker to access them through
NMHV	Nurses, midwives and health visitors (see Appendix 1 for more information about the characteristics of the UK NMHV workforce)
Nurse, midwife and health visitor entrepreneur	Those NMHV entrepreneurs involved in health-related activity (rather than activity with no connection to health or healthcare)
Innovation and entrepreneurialism	The boundary between innovation and entrepreneurialism is not distinct. Our operational differentiation is found in the methods section in chapter 1
Drivers	Broader forces encouraging entrepreneurial activity
Triggers	A specific event or circumstance that an individual describes as tipping their decision to become an entrepreneur
Our policy cut-off point for this scoping	March 2006

Chapter 1. Introduction and methods

This document is a report of the scoping exercise commissioned by the NCCSDO concerning the extent and character of nurse, midwife and health visitor entrepreneurial activity and its relationship to patient choice. In this chapter we set out the aims of this project and detail the methods of the different aspects of our scoping.

This scoping exercise had the following aims:

1.1 Project aims

- Develop definitions of nurse midwife and health visitor (NMHV) entrepreneurship in relation to current definitions of patient choice,
- Map the range and types of entrepreneurial NMHV activity across primary, secondary and tertiary health and social care provision in the state and independently provided sectors in the UK
- Conduct a review of available international published and grey literature concerning models of entrepreneurship in healthcare and related fields, of NMHV activity within this, and of policy initiatives in this area
- Analyse the extent of the evidence at a policy and local delivery level of both drivers and inhibitors of entrepreneurial activity by NMHVs, in particular related to the patient choice agenda and current NHS policy concerning contractual freedoms
- Using these sources, identify any design and delivery issues relevant to NMHV entrepreneurship that may promote better outcome including choice for patients, carers, and their families
- Identify gaps in current knowledge and elaborate key research questions in order to inform future SDO calls for Proposals.

There were five elements to our scoping:

1. Exploring understandings of the use of the terms entrepreneur and entrepreneurial

2. A review of published and grey literature for NMHV entrepreneurial activity, research and issues identified using electronic and hand searching and electronic scoping through e-lists (e.g. CHAIN and the Primary Care Research Network), via senior nurses involved in commissioning and web searches for examples of UK nurse entrepreneurship
3. Expert seminars
4. Policy mapping and analysis (Including analysis of patient choice)
5. Synthesis of evidence and identification of gaps in knowledge

1.2 Outline of the report

Our approach and findings are summarised in a short executive summary; Chapter 1 describes the five main methods of investigation and analysis that we adopted and explains how we delineated the available literature; Chapter 2 gives an account of the varied and changing use of key terms around entrepreneurialism within literature from business and management, social policy and psychological fields, for example intrapreneurialism and social entrepreneurialism and goes on to present literature about women entrepreneurs; Chapter 3 provides an analysis of NHS and other policy concerning overarching NHS priorities, the encouragement and enabling of contractual freedoms, the encouragement of innovative and entrepreneurial activity in nursing, midwifery and health visiting and patient choice; Chapter 4 provides a thorough and substantive map of the available literatures (both theoretical e.g. a categorisation of commissioning and financing of healthcare services, and empirical). It includes a discussion of the quality of the literature surveyed, a description of the process of categorisation and the creation of a typology of entrepreneurial activity and the identification of the numbers in each category by source of information (e.g. literature, e-scoping) and by sector. Analysis by categories and sectors of geographical spread, financial information and stated drivers and inhibitors, aspirational claims and the extent and character of any evaluations are included. Chapter 5 presents the findings of the expert seminars that we ran for nurse entrepreneurs and others; Chapter 6 summarises what we have learnt from the scoping and identifies the gaps in current knowledge and proposes areas for further research and how they might be addressed, including by primary research. It sets out the relevance for NHS policy of such subsequent work and identifies the limitations of

the study. Finally a number of appendices set out the bibliographic and other reference material that arose from the study.

1.3 The method of enquiry

The function of a scoping review is 'to map rapidly the key concepts underpinning a research area and the main resources and types of evidence available' (Mays et al 2001). A mixed method scoping approach was used. The elements are listed above and are detailed below.

1.3.1 Exploring understandings of the use of the terms entrepreneur and entrepreneurial

This involved a search through the major literature on these topics from business and management, social policy, and psychology. There were no formal inclusion criteria for this wide-ranging review as early discussions of the character of entrepreneurs date from the early 18th century and the type of literature in which such discussions occur is broad in nature and global in scope. We reviewed literature that discusses the character of entrepreneurialism, of entrepreneurs and various related concepts. This part of the scoping was facilitated by the consultant to the project. The literature on women as entrepreneurs was drawn from similarly wide and global sources in order to provide context for an understanding of NMHVs as entrepreneurs.

1.3.2. Review of published and grey literature

Electronic searches of databases

Bibliographic databases included: MEDLINE, CINHALL, AMED, EMBASE, MIDIRS, British Nursing Index, Health Management Information Consortium (HMIC), DH-Data (Department of Health), the Cochrane Library (including the Health Technology Assessment database), Web of Science (Social Science Citation Index), SIGLE (System for Information on Grey literature in Europe), Index to Thesis, Psycinfo, Social Care Online, and the National Research Register. The search also covered the EBSCO full-text collection of journals and a manual search of the Kings Fund Library data base..

Single and combined search terms, determined at an early meeting of team members, were used and initially included: 'entrepreneur\$', 'business', 'private practice', 'self-employ\$', 'intrapreneur\$' and 'social capital' which were related to a

second layer of terms 'Nurs\$', 'Midwi\$', 'Visit\$', 'Entrepreneur\$'. Additional terms were added in light of the low yield and after further discussion among the research team. These were 'social enterprise\$', 'mutuals', 'collectives', 'co-op', Private Midwi\$, Independent Midwi\$, and 'nursing workforce'. The above terms were used to search free text and subject headings. Free text searches are more inclusive as they pick up both.

A third layer of search terms were used in a search of subject headings to explore the contribution of such entrepreneurship to patient choice: 'patient choice', 'patient autonomy', 'patient decision making', 'patient or health services accessibility' and 'health services needs and demands'. These terms were not necessarily combined with the terms in both of the first two layers because we were looking for extra literature that did not necessarily contain all 3 concepts. We used these 'third layer' terms in combination with either of the first two layers. The number of additional publications identified in this way was very small (n=9). Although there is a considerable literature on 'patient choice' e.g. (Fotaki et al 2005) the only documents from this initial trawl linking NMHV 'entrepreneurship' with 'patient choice' were found in the midwifery literature. We considered undertaking a citation search of 6 – 8 key articles to track their influence but the literature was such that no such key articles could be identified. Subsequent searches focussed on the primary care sector and on midwifery because these were areas where existing evidence would suggest that the great majority of NMHV entrepreneurial activity is occurring (see Chapter 3 on policy drivers).

Electronic scoping through e-list networks

This is a fast moving field and it was recognised that there might be new or different activity that had not yet featured in published articles in mainstream journals. Through online UK e-group networks we made requests for any additional published/grey literature relating to entrepreneurial activities among nurses, midwives and health visitors. Eight e-group networks were contacted and an email distributed (Appendix 1.1). These groups were; CHAIN (Contact, Help, Advice and Information network (CHAIN 1 (140 members), Nurse UK list (163 members), Primary Care Nursing Research Network (100 members), Practice Nurse network (no. unknown), HV-School Nurse forum (90 members), RCN Nurse Entrepreneurs Forum (a subgroup of the Independent Nurse Managers Forum (300 members), Consultant Midwives e-group on Yahoo, Midwifery Research JISCMail and the RCN Research & Development network (distributed UK-wide, numbers unknown).

The electronic scoping resulted in 38 responses.

Hand Searching and Additional Searches for Grey Literature

To enhance the search for publications and to identify additional relevant papers, articles and reports we also hand searched (mainly at the KingsFund and Royal College of Nursing libraries in London) a range of speciality related journals/magazines: Community Practitioner (1998 Vol.71 - present), Journal of Community Nursing (1996 Vol10. - present), Independent Nurse (2005 - present) and Primary Health Care (2000 Vol.10- present), and three significant oncology nursing publications: The European Journal of Oncology Nursing, Cancer Nursing and the Journal of Clinical Oncology (1996 – 2005). We chose the speciality of oncology as an exemplar of the acute sector because we considered that it would provide the richest seam of entrepreneurial activity. There may be other activity in other specialities. In addition we investigated articles and news items available from a range of world wide web online sources (Appendix 1.2.).

Details of all identified documents were managed in a bibliographic management package, Reference Manager. Abstracts and reports from journalists, from database and hand search reference lists were assessed for relevance to the topic of the scope. An inclusive approach to the thematic documents was used, as the purpose was to uncover and describe what is known about the activities and behaviours of NMHV's involved in any entrepreneurial activities. The focus of the search was UK based but the international literature providing comparative examples was also identified.

Identification and assessment of the core documents

The assessment of the literature and other documentation proceeded in three stages. **In the first stage**, published articles identified through the database search were ordered chronologically according to publication date from 1996 to the present, to identify trends and policy change over time that might be specific to NMHV's entrepreneurial behaviours or activities. At this point it became clear that the category of 'intrapreneurial' activity had very 'fuzzy boundaries', with considerable overlap with other 'current' concepts as 'leadership', and 'innovation' in the healthcare sphere / between entrepreneurial and intrapreneurial activity. Therefore the search into intrapreneurial activity has not produced a definitive publications list. So while intrapreneurship is recognised in this review as part of the spectrum of

entrepreneurial activity (see Chapter 3), it was not possible to set clear definitional boundaries that would permit identification of a clear literature sub-set for NMHV intrapreneurship as a whole. Instead, examples of 'intrapreneurial' activity are employed in the review to highlight the intra-institutional end of the entrepreneurial spectrum of activity, for example key papers on 'one-to-one' or 'caseloading' midwifery within the NHS. This resulted in 462 papers and of these, 143 met the inclusion criteria at the first stage (see Table 1.1).

The second stage involved quantifying the papers according to continent of origin. The core literature for the scoping exercise focuses on the UK literature and this is the criteria for inclusion in the literature for analysis and the table of published papers below. Examples from the international literature are drawn on for example where independent contractor models in nurse/midwifery/health visiting are more widely practised (e.g. independent midwifery practice in New Zealand) and there is empirical research on which to draw out any UK relevant lessons. The amount of literature worldwide does not necessarily represent the amount of actual activity.

At **the third stage**, the UK papers were allocated into one of six broad categories of documentation:

- Empirical research paper (these are listed in Appendix 4.1.)
- Theoretical 'think piece' (describing a model, theory or framework)
- Opinion piece (professional, views, thoughts, exertions)
- Personal narrative (practitioner and user description of working practice providing primary evidence of an activity)
- Journalist feature article (of an entrepreneurial initiative /activity)
- Brief news item

Table 1.1. Published papers specific to UK entrepreneurial activity amongst N,M and HV's

Literature Type	
Empirical research paper	13
Theoretical or academic paper	13
Opinion piece	21
Personal Narratives	31
Journalist Feature Article	19
Brief news items	5
TOTAL	104

Beyond this literature is a large body of unpublished or locally published material. Table 1.2 is included as a non-exhaustive example of the grey literature within only the primary care field. It shows the balance of the types of literature that are extant and is indicative of the whole field.

Table 1.2. Grey Literature specific to N and HV's working in Primary Care settings in the UK

Literature Type	
Empirical research paper	4
Theoretical or academic paper	-
Opinion piece	12
Personal Narratives	21
Journalist Feature Article	36
Brief news items	46
TOTAL	119

1.3.3. Expert seminars:

The seminars followed on from the comprehensive literature searches and were intended to test and refine the understanding of entrepreneurial activity in practice through discussing our findings with key stakeholders working in the field. In the seminars we invited participants to draw on their own experience to provide feedback on our definitions of entrepreneurial practice, and on our findings with regard to the breadth of such activity and the drivers and inhibitors to its development. We also explored participants' views of the intended and actual impacts of entrepreneurial activity, particularly its contribution to patient choice. Throughout the discussions participants were invited to flag up further sources of literature and examples of good practice.

Seminar participants

The seminars were designed to bring together small groups of stakeholders with different expertise and knowledge about nursing, midwifery and health visiting entrepreneurial activity in health care gained through their experience as providers, commissioners, service users and consultants working at local and national levels. For this purpose, 'users' were defined as user representatives from charities or user groups rather than individual users. Stakeholders from each of these groups were identified from the literature searches and from contacts known to members of the research team. Participants were invited to the seminars by an email with an accompanying letter that provided detailed information about the aims and context of the study. Overall, 49 people were approached and many of these expressed considerable interest in participating in the study. However, because of the tight time scale for the project, which meant that seminar dates had to be fixed before inviting potential participants, many of those initially approached were already otherwise engaged. Where people invited were unable to come, we asked for and followed up their suggestions for alternatives. We followed up two of the individuals unable to come to the seminars separately to ask them about their views on the subjects covered in the seminar. The initial intention was to run three seminars, but one of these was cancelled as too few participants were able to attend on the date selected. In the event, two seminars took place in April 2006. The names and job titles of the 18 people who participated are listed in Appendix 1.5 with members of the research team that attended the sessions also included. In the second seminar one participant had to cancel at the last minute and another did not turn up. They were followed up subsequently by phone to ask their views on the subjects covered in the

seminar. A wide range of interests was represented at the seminars, but unfortunately with less representation from user groups than was hoped for, although six such groups were invited.

Seminar format

In advance of each seminar, participants were sent a copy of a briefing paper that explained how we had approached the task so far and raised some issues relating to entrepreneurship to provide a stimulus for thinking in advance of the seminar discussion. The paper outlined the preliminary findings on types of entrepreneurs and an initial analysis of the inhibitors and drivers to entrepreneurial practice. Each seminar was attended by members of the research team who began by outlining the purpose of the study, shared the preliminary findings of the research team in two presentations and facilitated the discussion. The first presentation reported the preliminary findings on the current scope and nature of entrepreneurial activity in nursing, midwifery and health visiting. This was followed by a facilitated discussion exploring participants' perceptions about the factors that shape, enable and constrain entrepreneurial activities in this field. The second presentation covered the aims and impacts of the various entrepreneurial activities identified in the scoping review. This was followed by a facilitated discussion about the potential impacts of these activities including the effects on patient choice. The objective of the sessions was a free ranging discussion and we did not necessarily aim to achieve consensus among the participants. In order to encourage open expression of views, it was agreed that the Chatham House Rule was applied meaning there was confidentiality within the group and also that anything reported was done so without attribution. Ethical clearance via COREC was obtained before the seminars occurred and participants gave signed consent to their participation. Each participant was asked to notify the research team should they require individual NHS R&D clearance.

The discussions were audio-taped with the participants' permission and subsequently transcribed. Summaries of the points raised in each discussion were prepared from the transcripts and copies circulated to the participants.

Analysis of seminar findings

The transcripts were analysed using a modified version of the 'framework' approach developed by Ritchie and Spencer (1994) for use in applied policy research. The data were analysed by taking different themes in turn, extracting the sections relevant to that theme from the transcripts from each seminar and grouping these

together. The themes were the subject areas of discussion including drivers, inhibitors, discussion on concepts such as choice, and outcomes of NMHV entrepreneurial activity. The analyses for each theme were then taken independently by two of the research team (RL and CH) and cross-checked and finalised by consensus.

1.3.4. Policy mapping and analysis

The aims of this part of the scoping were i) to identify and describe the broad UK policy background that has a direct or indirect influence on NMHV entrepreneurship and patient choice by affecting the context and ii) provide a more focussed discussion of UK health policy and other statements and documents from the UK's Health Departments that have a direct bearing on this subject either because they set out explicitly to enable or promote NMHV entrepreneurship or have the effect of doing so or have the effect of inhibiting it. After setting out the range of health policy initiatives over a ten year period (since 1996) and identifying changing priorities over time where these are apparent, we discuss in more detail how general priorities for the NHS have affected NMHVs either explicitly or implicitly, some of the possible unintended consequences of particular policies, and possible contradictions with other health policies that may compromise effectiveness. The policy mapping and analysis is not an exhaustive review and includes only the policy or other communications that the research team believe are of relevance to the topic of the scoping exercise. Policy of only indirect effect, such as overall treasury policy, is considered only briefly while policy of more direct relevance, such as that enabling primary care trusts (PCTs) to commission health services from a diverse range of provider types, or policy with specific focus on NMHV roles, is discussed at more length. To help with this policy analysis, we have drawn on the work of a number of commentators and think tanks. We adopted a critical approach to analysis of policy formation, its expression and the way it is taken up and responded to by different actors. Some of our analysis was informed by aspects of discourse analysis, an approach taken in similar studies by the principal investigator (Traynor 1999) which focuses on subjecting taken for granted definitions and argumentative strategies to detailed scrutiny (Alvesson and Kärreman 2000; Fairclough 2001; Fairclough 2003). One focus of such analysis was on the suggestive use of the term 'entrepreneur' in government literature as a signifier associating positive value with a range of preferred behaviours.

1.3.5. Synthesis of evidence and identification of gaps in knowledge in final report.

The results of the policy analysis were brought together with the review of entrepreneurial activity and the findings from expert seminars and an overall summary and specific range of questions for further research were articulated (See chapter 6).

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Chapter 2 Setting the entrepreneurial scene

This chapter sets out to explore the wide-ranging literature which discusses, describes and sometimes defines entrepreneur, entrepreneurship and associated terms. It will consider first of all what is meant by these terms and the historical development of definitions from a variety of disciplines and approaches and goes on to explore some of the implications across health care. It will conclude with a discussion of women as a newly emerging group of entrepreneurs.

2.1. What is meant by 'entrepreneur'?

A great deal has been written about entrepreneurs and entrepreneurial activity, initially from economics and more recently in the business and management literature. Though some of this writing is narrative and celebratory of individuals' achievements, rather than analytical, there is a separate strand of literature that seeks to understand and theorise the nature and context of entrepreneurship. The term has taken on currency, more recently, within the healthcare literature (Silver 1987), and its role within NMHV is the focus of the main part of this scoping exercise.

The use of the term entrepreneur or entrepreneurial is associated with a range of behaviours and activities that are preferred by particular groups in various contexts (Baum & Locke 2004). Therefore its use is not innocent. Both inside and beyond the literature, the term has been loaded with positive meaning as the driver of change and development (Drucker 1999). This is in spite of the fact that in the UK 30% of all small business start ups will fail within the first 12 months and that this figure rises to 55% within 3 years. It is notable that within the literature there remains a paucity of data relating to entrepreneurial failure. After a preliminary acquaintance with definitions and use of the term entrepreneur, it became clear that certain activities, that might meet most definitions of entrepreneurial activity, may not be labelled in that way by nurses, midwives and health visitors, not least because of negative stereotypes associated with the role which some see as contrary to the nature of professional work and to the trust and ethical values associated with healthcare (Koivusalo & Mackintosh 2004) (Nicholson & Anderson 2005). This was borne out in the expert seminars, where all the participants acknowledged they were involved in entrepreneurial activity in some way, but preferred a range of terms other than

'entrepreneur' - such as 'public servant' or 'business woman' - to describe themselves.

Given this context, decisions about how to determine the scope of our inquiry were not straightforward precisely because these definitional issues were a feature of the discourse itself. Because of this, we adopted an inclusive and pragmatic approach to our conceptualisation and our searches, some of which were detailed in chapter 1.

2.1.2 Early Definitions

The French word 'entreprendre' means 'to do something' and usually refers to a person who is active and gets things done. The first definition of entrepreneur is attributed to the French economist Cantillon (1680-1734) who saw entrepreneurs as having the skills and motivation to assume monetary risk during periods of difference in demand and supply. The essence for Cantillon of entrepreneurship is a personal alertness to such opportunities for gain (Blaug 2006). Later, Jean-Baptiste Say, writing in 1800 defined an entrepreneur as 'one who shifts economic resources out of an area of lower and into an area of higher productivity and greater yield'. He argued that entrepreneurs use periods of change and uncertainty to enable them to achieve this. Schumpeter (1883 - 1950), writing during the 1930s, suggested that the entrepreneur was an innovator who produces and markets new goods or services, and makes new combinations of already existing materials and forces, creating innovations rather than inventions. For him, rather than being someone who is highly speculative in behaviour, the entrepreneur maximises the benefits of technological advance, and can benefit from practical guidance. Schumpeter's typology has influenced subsequent understandings. According to him, entrepreneurialism can be characterised by:

- 1 The introduction of a new good
- 2 The introduction of a new method of production
- 3 The opening of a new market
- 4 The conquest of a new source of supply of raw materials
- 5 The creation of a new organisation of an industry

It is the act of combining in this context that he considers key.

Schumpeter's work looks at the activities and context of the entrepreneur. More recently, texts have focussed on the definitional boundaries of entrepreneurs and their organisational contexts to answer questions about what activities are

entrepreneurial, when they or their organisational contexts move into the mainstream, what is deemed failure and what happens to the entrepreneurs and their organisations after this? International bodies such as the Office for Economic Co-operation and Development (OECD) and Global Entrepreneurship Monitor (GEM)¹ use various types of national data to provide comparative information on these issues (OECD 2006). This data demonstrates the levels of such activity and the elements that contribute to this and enables a better understanding of national organisational context (George.G, Hayton, & Shaker 2002). This in turn can lead to policy change to promote entrepreneurialism that is culture specific. See Chapter 4 for more details.

Within the scope of these debates a great many writers have been keen to define what exactly this phenomenon of entrepreneurialism is. The breadth of these definitions and characterisations does not give a sense of either consistency of focus or emerging consensus. Many definitions that we have reviewed are normative statements or promotions of the concept. The most notable feature of many definitions included is that they are loaded positively, and as such they are available to those who wish to evoke or encourage positive behaviour or characteristics without necessarily being precise about what they are. However, although this writing has not produced a consensus definition, Herron and Herron propose that 'entrepreneurship theory may be used effectively by nursing to build professional practice models which foster the joint realisation of both nursing and organisational goals' and identify two general features within business. First, entrepreneurship is about 'innovation through reallocation or reconfiguration of resources for the purpose of creating benefit' and second, that the entrepreneur possesses an 'awareness or alertness to the opportunity' to take such action this is in line with the early definitions of entrepreneurship (Herron & Herron 1991).

¹ The **Global Entrepreneurship Monitor (GEM)** research program is an annual assessment of the national level of entrepreneurial activity that was established in 1997. GEM is the world's largest and longest-standing study of entrepreneurial activity and is scaled on population not labour force in the formal sector rather than informal sector. The results of GEM data analyses are used as key benchmarking indicators by regional, national and supranational authorities around the world. GEM surveys analyse total entrepreneurial activity (TEA) defined as the share of adults in the population aged 18-64 who are actively involved in starting a new business or managing a business less than 42 months old. Data forms two categories; the *nascent entrepreneur* an individual who has taken action and created a new business in past year and expects to share ownership but has not yet paid salaries and wages for more than 3 months, and *owner /manager* of a new firm that has paid salaries and wages for more than 3 months but less than 42 months (Reynolds et al. 2002)

2.2. 'Intrapreneur': the entrepreneur within the organisation

Because, as we will show later, many NMHV entrepreneurs operate inside large organisations (usually the NHS), we examine the concept of 'intrapreneurship'. Entrepreneurship is not confined to individual start up organisations, although as a mould breaking activity it can be seen to threaten the status quo within many existing organisations. Within this issue lies another of the historical definitional dilemmas of entrepreneurship: do entrepreneurs stabilise disequilibriums by identifying new products, or do they destabilise the status quo in order to bring about change and advance? One reinterpretation of this question in the 1980s was the development of intrapreneurship, that is the encouragement of entrepreneurial activity within the organisation to reinvigorate established businesses, a classic example of which had been the development of the Post It note by Art Fry at 3M launched in 1981. The publication of Pinchot's *Intrapreneuring: Why You Don't Have to Leave the Corporation to Become an Entrepreneur* in 1985 further clarified the specifics of this role where the creative innovation required is encouraged by and benefited from within and on behalf of the corporation (or NHS). Moss Kanter suggests in her seminal 1988 article *When a thousand flowers bloom* (Moss Kanter 1988) that it is important to actively facilitate such innovation which she describes as uncertain (because of both the creative and organisational processes), fragile (because it is knowledge intensive with steep learning curves), political (because of its competition with the status quo), and imperialist (because it crosses boundaries and territories). Intrapreneurship therefore needs the right conditions in which to flourish. Moss Kanter suggests that these are found where organisations are flexible, provide for quick action and intensive care, coalition formation and connectedness.

Although there continues to be much interest in the 'conventional' business entrepreneur, later literature which examines broader conceptualisations of entrepreneurship proved more relevant to the focus of this scoping. It is to these we now turn.

2.3. How do we recognise an entrepreneur? Studies of characteristics and motivation

A further range of literature within psychology and, more rarely, psychoanalysis, from approximately 1980 onwards, sets out investigations into the personal characteristics of entrepreneurs, in much the same way that leadership and leaders have been studied. Some such studies attempt to discover whether difference from their peers is

associated with those identified as successful entrepreneurs (Jennings, Cox et al. 1994). Many of these studies do not differentiate between entrepreneurs and senior managers in leadership roles within corporations on the grounds that similar traits, those of growth, innovation and flexibility are found in both groups and that personality traits show there are more similarities across the two groups than within the group of conventional 'entrepreneurs', small business owners, many of whom, it has been argued, do not possess 'genuine' entrepreneurial traits because they 'inherit or simply replicate an existing or proven form of business' (Watson 1995). Almost all, however, are men. This focus on personality trait and behaviour remains a subject of interest especially when combined with information on context (George.G, Hayton, & Shaker 2002), be it organisational or cultural.

In addition, the concept of the **serial entrepreneur** also emerged during the 1980s to support the notion of individual predisposition to entrepreneurial behaviour (MacMillan 1986). The serial entrepreneur is the individual who over a lifetime is involved in a number of business start ups, often moving away from their original business area to do so. Research here is less developed but there are indications that context in relation to this group is also important. Exploration of the activities of existing entrepreneurs undertaken through our research workshops suggest this is a recognisable phenomena in healthcare, but sometimes involves transitions between intrapreneuring in the NHS, and entrepreneurship.

2.4. Social entrepreneurialism in an International context

Much of the 'entrepreneurial' work of NMHV's has been assumed to be 'social entrepreneurship' (see chapter 3). The term social entrepreneur is inextricably linked in an international context with the work of Bill Drayton the founder of ASHOKA in the USA, an organisation set up by him in 1979 to develop social entrepreneurs who, he suggests, recognise when a part of society is stuck and provide new ways to get it unstuck. Social entrepreneurs are characterised by him as having:

1. a powerful new system-changing idea,
2. creativity, both in goal-setting and problem solving,
3. potential for widespread impact,
4. entrepreneurial quality that is required to engineer large-scale systemic social change and
5. strong ethical fibre since significant social change requires those affected to

take many leaps of faith which individuals will not take if they do not innately trust the proponent of such change.

Social entrepreneurs are said to find what is not working and solve problems by changing the system, spreading the solution and persuading entire societies to take new leaps. In this sense they differ from those running social enterprises who seek to make improvements within existing systems in that they seek system change (Hartigan & Billimoria 2005). In Drayton's words 'Social entrepreneurs are not content just to give a fish or teach how to fish. They will not rest until they have revolutionised the fishing industry'. This work has been described and developed by (Bornstein 2004) drawing on Drayton's work promoting social entrepreneurs. Drayton's methods require a radical approach to assessing ideas, programmes and the people behind them. ASHOKA's work which began in America, where the notion of public and community services is less embedded, uses a terminology which attracts both the affinity felt for entrepreneurial activity in America with the social responsibility more acceptable to other parts of the world. In Europe the development of the Schwab Foundation for Social Entrepreneurs in 1998 is seen to complement the macro work of the World Economic Forum at a local micro level (Hartigan & Billimoria 2005).

Meanwhile the World Health Organisation (WHO) had already explored the role of social entrepreneurship in health through the development of its Healthy Cities project (de Leeuw 1999)². This movement aims, through multilevel interventions and intersectoral collaborations, including social enterprise, to improve the health of cities around the world. Social entrepreneurship and social enterprise is now the subject of many books, for example Bornstein and Law & Baderman (Bornstein 2004; Law & Baderman 2006), organisations, for example ASHOKA and UnLtd; academic papers, for example Shaw and Wilson (Shaw, Shaw, & Wilson 2002) and whole academic departments for example the Center for the Advancement of Social Entrepreneurship (CASE), Duke University's Fuqua School of Business or the Skoll Centre for Social Entrepreneurship, Said Business School, Oxford University, UK; all now help to trace the development of social entrepreneurship and its interpretation. Such work has also provided a bridge into a greater understanding of and engagement with the needs of

² Healthy City's programme (now in its 4th phase 2003-2008) specifically targets health inequalities and urban poverty. It is established in all 6 WHO regions of the world and has over 1200 cities and towns involved from over 30 countries.

those that Prahalad (Prahalad 2004) describes as being at the bottom of the pyramid, to improve the quality of life in some of the most 'difficult' and 'excluded' communities. Social entrepreneurs identify unmet social need and generate solutions based upon a close understanding of the views of those most directly affected. At the same time multinational corporations are seeing an expanding market they have so far overlooked. Collectively, the world's 5 billion poor have vast untapped buying power. They represent enormous potential for companies who learn how to serve this market by providing the poor with what they need, but often developing this market falls to those who start through the motivation provided by social entrepreneurs.

An example of this is the Grameen Foundation USA founded in 1997 by Alex Counts to extend a microfinancing initiative first started by Indian Economics Professor in Bangladesh, aimed at assisting poor/low income women to develop microenterprises in order to break through the poverty barrier. Microenterprises are described as very small businesses consisting of less than 10 employees which form the economic backbone of many countries around the world although many are officially 'invisible'. In the main they are operated by entrepreneurial individuals often those from lower income brackets and women. This foundation is a not for profit organisation that uses microfinancing and innovative technology as the means to address issues of global poverty and support employment opportunities for some of the world's poorest people. The United Nations declared 2005 as the International year of Microcredit, advocating more financial sector involvement to support the often untapped, entrepreneurial spirit of individuals in communities around the world.

2.5 Entrepreneurs and Social entrepreneurs: the UK experience

The OECD has consistently identified the UK economic environment as favourable for the development of entrepreneurial activity because it is the second least regulated economy in the world, yet as the 2004 GEM report (Harding 2005) on the UK shows, a number of local factors continue to militate against an increase in UK activity above 6.3% total entrepreneurial activity (TEA) of the adult workforce population. These can be summarised as:

- A need to build networks of entrepreneurs
- The slow speed of development, especially in the transfer of technological advances from Universities into the entrepreneurial community
- Aspirational modesty, especially within the women entrepreneurs and those from ethnic minorities

- Problems in accessing finance, especially for women and ethnic groups
- An unhealthy level of fear of failure as part of UK culture

The situation is however improving. The Secretary of State for Trade and Industry in a speech to the Ethnic Minority Business Forum in March 2006 reported that there were half a million more businesses today than in 1997 and 1,500 new businesses starting up every day. In our literature review we have noted the changing fortunes of the term entrepreneur in UK social policy and government speeches (also see Chapter 3). Government initially promoted the term entrepreneur with an expectation that it could come to have the positive meaning that it is generally accorded in the US context. Social enterprise and social entrepreneurs became the engine of change for public services sector. The term first came to wider public prominence in the UK in the first policy speech on 2nd June 1997 by the new Prime Minister Tony Blair, given on the Aylesbury Estate in the London Borough of Southwark where he stated:

'For the same reason we will be backing thousands of 'social entrepreneurs', those people who bring to social problems the same enterprise and imagination that business entrepreneurs bring to wealth creation. There are people on every housing estate who have it in themselves to be community leaders - the policeman who turns young people away from crime, the person who sets up a leisure centre, the local church leaders who galvanise the community to improve schools and build health centres.'

This was endorsed in the same year by Leadbetter's (Leadbetter 1997) publication for the think tank Demos in which he describes the social entrepreneurs as applying the same enterprise and imagination to social problems as commercial entrepreneurs apply to wealth creation. Because of this focus on welfare and social benefit, social entrepreneurialism has been seen as an appropriate model for developing nursing entrepreneurial activity, particularly when applied to the community setting, although it has been recognised that activities in healthcare, whether social or commercial, will require effective regulation to safeguard patients (Saltman, Busse, & Mossialos 2002). In the expert seminars, some participants expressed scepticism about the current emphasis on the concept of social entrepreneurship in the NHS. It was suggested that the term was a 'smokescreen' used to disguise and make more acceptable the government's wish for greater plurality of service providers.

The development of the critical networks required for social entrepreneurship to function effectively has also been supported in the UK by developments such as

UnLtd, also known as the Foundation for Social Entrepreneurs, founded in 2000 by seven partner organisations who form the Board of Trustees to promote and develop the major contribution social entrepreneurs can make to society. UnLtd's Millennium Awards are funded by the income generated from an investment of £100 million given to UnLtd by the Millennium Commission in the UK, one of the National Lottery distributors.

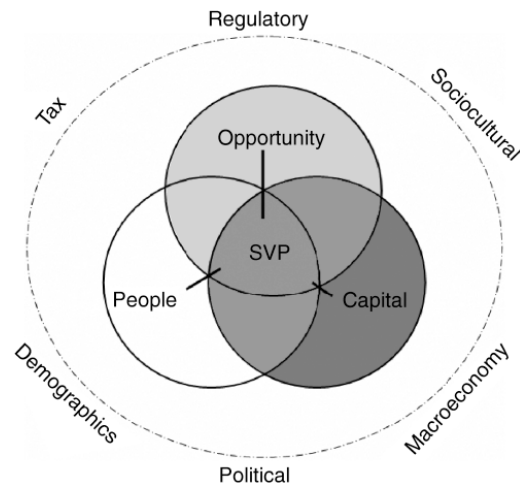
We have also seen the beginning of the use of the more acceptable term 'enterprise', as in the institution of the Department of Health Social Enterprise Unit set up in 2006 following the original Unit set up in the Department of Trade in 2002. Our review has suggested that there is a sense in which the concept of enterprise does not carry the connotations of radically changing existing systems that the work of social entrepreneurs does. This perhaps reflects a more mainland European position with a resistance to the concept of free markets.

The GEMNetwork has also now developed specific reports on social entrepreneurs as a subsector of the enterprise economy and the relationship between these sectors becomes of increasing importance. In the expert seminars, participants made the point that commercially and socially driven activities are not necessarily at odds and suggested that a single individual could be both a commercial and social entrepreneur, since there is 'such a lot of interaction' between the two activities. Developing understanding of the similarities and differences between social and commercial entrepreneurship enables a better understanding and appropriate expectations from policy makers of the contributions that each can make. These are already the subject of discussion (Shaw, Shaw, & Wilson 2002) in the UK and are now being considered in relation to a future research agenda (Austin, Stevenson, & Wei-Skillern 2006) Austin *et al* suggest :

- Market failure will create differing entrepreneurial opportunities for social and commercial entrepreneurship.
- Differences in mission will be a fundamental distinguishing feature between social and commercial entrepreneurship that will manifest itself in multiple areas of enterprise management and personnel motivation. Commercial and social dimensions within the enterprise may be a source of tension.

- Human and financial resource mobilization will be a prevailing difference and will lead to fundamentally different approaches in managing financial and human resources.
- Performance measurement of social impact will remain a fundamental differentiator, complicating accountability and stakeholder relations.

Figure 2.1. A framework for understanding social entrepreneurialism



Austin *et. al.*'s analytical framework for social entrepreneurship (see Figure 2.1) is presented as a Venn diagram with the opportunity circle at the top, because this is often the initiating point for entrepreneurship. The two enabling variables—people and capital resources—are the bottom circles. The three circles intersect, reflecting the overlapping and interdependent nature of the variables. At the centre is the Social Value Proposition (SVP) as the integrating variable. Surrounding all three circles are the contextual forces shaping the other variables and requiring scrutiny by the entrepreneur.

In considering the differences between commercial and social entrepreneurs and the role they will play it is important to know who the new entrepreneurs might be.

From the preceding data on nurses it is apparent that the vast majority of nurse entrepreneurs will necessarily be female, therefore an understanding of how women now appear in this role is essential.

2.6. Women as entrepreneurs

One of the main criticisms of much of the classical entrepreneur literature as, we have previously noted, is that it has focussed on successful individuals who are

predominantly male and involved in entrepreneurial activities associated with personal and financial gain, rather than social objectives. This does not reflect either the purpose or gender profile of nursing in the UK (as set out in Appendix 1). Much of the methodology was developed during investigations of the behaviours and activities of male entrepreneurs. It is argued that these may not be the most appropriate measures to investigate female entrepreneurship. Until relatively recently women's entrepreneurship was considered 'invisible' and studied only as a sub-field (Hisrich and Brush 1987). Contemporary researchers are now beginning to question the relevance of some these earlier findings particularly within the context of gender differences. Following the first publication on female entrepreneurship, a qualitative study investigating the motivational drivers and inhibitors of 20 female entrepreneurs, by Eleanor Schwartz in 1976 in the USA (Schwartz 1976; cited in Hisrich and Brush 1987), an increasing numbers of studies have been conducted around the world. While much of the earlier focus was mainly on describing distinctive individual characteristics, goals, motivations and attitudes towards start-up, as the 1990's witnessed more women around the world entering the self-employment/new business arena, new themes for female entrepreneurs began to emerge in the literature. These themes begin to capture some of the unique differences between the genders in relation to:

- Individual characteristics and competencies, for example why women were motivated to engage in entrepreneurial activities, what influenced the types of business they were involved in, their attitudes and educational and business experiences.
- Business characteristics; financial resources (access and availability to start-up and growth capital and their relationship to business survival, management skills, including risk taking propensity, performance and growth strategies, barriers and challenges
- Environmental/cultural factors such as family-related factors.

Self-employment is not synonymous with entrepreneurship but these terms inherently overlap and as such, provide an avenue through which to better explore entrepreneurial characteristics including differences between the genders. For example, men and women view success differently men tend to evaluate success based principally on goal achievement measured in terms of financial profitability (business and personal income), whereas women, particularly those in more 'traditional female' industries such as retail, hospitality and services rather than the

non-traditional more male, dominated industries, emphasise life factors as part of their measures of success, control over their destiny, ongoing relationships with clients and sense of fulfilment.

Knowledge about female entrepreneurship globally rests on the North American literature as the most researched continent, less information is provided from Europe but does contextualise the final section that details the evidence regarding female entrepreneurship in the UK.

2.6.1 Female Entrepreneurship: Global context

Globally women make up more than half of the workforce (UNIFEM Gender Fact Sheet No.4)³. The Global Entrepreneurship Monitor (GEM) annually provides a map of entrepreneurial activity worldwide. The most recent data (the 7th GEM) from across 35 countries, involving a total labour force of approximately 784 million people, finds that 1 adult in 11 is an entrepreneur with wide variations in the types and levels of activity, although women still form a minority among all entrepreneurial initiatives and more would do so if it wasn't for fear of failure. A recent report bringing together the findings of the second OECD conference on Women's entrepreneurship in Small and medium sized enterprises(SME's) found that in many countries, including Brazil, Ireland, Spain and the USA, women are now starting up new companies at a faster rate than men (Eurochambers 2004).

According to GEM the percentage of men or women starting up their own businesses and becoming potential employers is greater in middle-income countries (Argentina or China, South Africa) compared to high-income countries (Japan or the USA) based on their per capita GDP and GDP growth rates. Further analysis of the type of start up activities identified demonstrate that consumer-oriented businesses outnumber businesses started up in the service sector in the middle income economies while high income economies are twice as likely to have more new

³ **Unifem** is the Womens' Fund at the United Nations providing financial and technical assistance to innovative programmes and strategies to foster women's empowerment and gender equality. Placing the advancement of women's human rights at the centre of all of its efforts, UNIFEM focuses its activities on four strategic areas: (1) reducing feminised poverty, (2) ending violence against women, (3) reversing the spread of HIV/AIDS among women and girls, and (4) achieving gender equality in democratic governance in times of peace as well as war. <http://www.sdchefs.com/displaypage.cgi?http://www.unifem.org/about/>

business services (Minnitti et al. 2005). Globally male entrepreneurial activity remains greater than female entrepreneurial activity within low, middle and high income countries. The two primary reasons male or females become involved in entrepreneurial ventures are;

- business opportunity (desire to take advantage of entrepreneurial idea) this was similar between men and women, -77.9% men choose entrepreneurship in order to exploit an opportunity compared to 71.4% women) or
- necessity (employment options either absent or unsatisfactory) - necessity was a factor for just 19.1% men compared to 24.8% women (Minnitti et al. 2004)

In terms of the principle drivers and inhibitors, current literature focuses on the notion of initiating or 'triggering' events in relation to start-up entrepreneurial activities, and triggers influenced by internal and external organisational factors . These have been classified as;

- push (unemployment or job dissatisfaction) or pull factors (market opportunities).
- negative (divorce or job dissatisfaction) or positive circumstances (windfall inheritance or invitation from a supplier);
- controllable forces(planned deliberate strategy) or uncontrollable forces (sudden death of family member) (Morris et al. 2006).

While governments, industry and policy makers may recognise that women are a potentially important and latent source of economic growth, global recognition of women's enterprise initiatives and their influence on policy remains limited despite worldwide policy efforts aimed at providing greater support to would-be female entrepreneurs (Harding et al. 2004).

2.6.2 Global context: numbers

Overall the number of women starting up new businesses is on the increase (Acs et al. 2005) and a positive correlation has been shown between rates of female entrepreneurship and economic growth (Reynolds et al. 2002)(p. 24 Section 3). However, GEM surveys conducted between 2001 – 2004 continue to report a persistent gap between the levels of male and female entrepreneurship, although this

gap varies between countries, with the most prominent gap observed in high income economies where the opportunity-driven versus necessity-driven factors may be swayed by availability of healthcare and childcare support (Minnitti et al. 2005).

It is estimated that women-owned businesses account for between one quarter and one third of businesses in the formal sector and likely to be much higher in the informal sector (where many small businesses may fall under the tax radar becoming officially invisible). The magnitude of this latter activity may in part be necessity-driven, particularly where national income per capita is low and there is a lack of alternative employment opportunities. Alternatively in very high income countries entrepreneurial individuals are more opportunity-driven having access to more resources and thereby more motivated to develop ideas, take risks and exploit opportunities (Minnitti et al. 2004). One study found that levels of female entrepreneurial activity are more markedly related to national per capita income citing a greater employment sensitivity in terms of the local environment and non-monetary incentives such as necessity, flexibility, family and social needs (Burke et al. 2002). However, the number of women-owned businesses in the UK remains low by comparison to many other countries in North America, Australasia, Europe and countries in the Far East and South America (Reynolds et al. 2002).

2.6.3 Global context: characteristics

Women are more likely to start up new enterprise in the service sector. The peak age to become involved in women-owned enterprise is 25-34 years particularly in low/middle income countries. Often these women have minimal or no secondary educational preparation compared to women in high income countries who are slightly older, aged 35-44 years and better educated at start up (Minnitti et al. 2004). As necessity is often the main driver of women-owned business, risk is minimised by starting up smaller businesses often consumer-oriented that need less start-up capital than those developing service oriented businesses. As a consequence many of these businesses tend to grow more slowly and create potentially fewer employment options for others.

2.6.4 Global context: drivers

Female enterprise is generally classified as necessity-driven rather opportunity-driven and covers a number of personal and socio-economic factors such as age, education, previous work experience, the influence of other female entrepreneurs

social and family circumstances (Minnitti et al. 2005). For many women, particularly in lower income countries, being able to generate income and gain independence while meeting family and social responsibilities is both liberating and empowering (Minniti et al. 2004; Sheikh et al. 2002; Kantor 2001). While there are many key similarities in the personal factors that influence an individual's move towards entrepreneurship, the primary similarity can be found in their motivation for starting up a new business venture, financial security, need for autonomy and a response to a business opportunity. There is little agreement in the literature as to personality and personal attributes. Although previous work experience and perception of success does seem to be a key observed differential between men and women entrepreneurs, other notable differences principally relate to :

1. Emphasis- men tend to emphasise the greater desire to be their own boss with the aim of increasing personal income, whereas women, in addition to being their own boss, stress the need for personal challenge, greater job/life satisfaction, independence and flexibility to meet combined work family responsibilities.
2. Necessity- the need to work and earn an income is more widespread among women than men, largely due to unemployment or lack of alternative work opportunities. Necessity is particular factor among women in low income countries where the opportunity to necessity ratio is 1:7 compared to 1:6 in high income countries(Minniti et al. 2004)

2.6.5 Global context: barriers and constraints

Commonly, men and women experience a range of similar constraints mainly at the start up stage of a new business, however this maybe more pronounced among women as a result of societal perceptions of women, their roles and responsibilities (Kantor 2001). However, a number of specific cultural and practical barriers face women entrepreneurs in many countries and this has major implications for policy makers. Some of the key differential barriers include perceived difficulty in accessing external business financing both at start-up and when needing to grow a new business venture, being less likely than men to be members of business or employers' associations and women's apparent disinclination to take on risk compared to men. Other factors include a reluctance to transform business ideas in to practice due to a lack of confidence, a fear of failure, lack of role models, limited

mentoring opportunities and networking possibilities (Minnitti et al. 2005). Additional factors that have been reported by the Womens' Enterprise Development Organisation⁴ include limitations imposed by location and mobility, social and family responsibilities, factors that may become magnified among women who have a disability (Kantor 2001).

The USA where there is the greatest amount of literature, may not reflect contextual and cultural dynamics in other countries such as the UK.

2.6.6 Evidence from North America: context of female entrepreneurship

Women-owned businesses are the fastest growing sector in the business markets in the United States and since 1997 have grown at nearly twice the rate of all US firms (17% v 9% respectively) (Centre for Women's Research 2004). It is reported by the Centre that women owned businesses (defined as privately held firms majority owned, 50% or more by women) are driving economic growth and are a equal financial competitor to all other business growth.6.2.1 - numbers of female entrepreneurs

Research data gathered from the United States Census Bureau and tabulated by the Centre shows that as of 2004, approximately 10.6 million, nearly half (48%) of all privately-held businesses, are part or solely woman -owned and employment through these businesses has expanded at twice the rate of all firms (24% v 12%) with increasing economic dominance (39% v 34%). Another 4 million (50-50) are joint women and men owned businesses. Overall this means that 1:18 women are business owners and 1:5 women from ethnic minorities have their own business enterprise (Harding et al. 2004)

2.6.7 Drivers of female entrepreneurship

The principle drivers of American female entrepreneurs reflect the drivers of women world wide including; the inspiration of launching an entrepreneurial idea

⁴ The Women's Entrepreneurship Development and Gender Equality (**WEDGE**), spearheads SEED's work in the field of female enterprise. **The SEED network** is an on-line home for women setting up their own businesses.

http://www.ilo.org/dyn/empent/empent.portal?p_docid=SWEKNOWLEDGE&p_prog=S&p_subprog=WE

and frustrations in previous work environment (study of 800 male and female entrepreneurs undertaken by the National Foundation of Women Business Owners (NFWBO) cited by Centre for Women's Business Research 1998). In addition, women starting up on their own tend to be older than their male counterparts, maybe the oldest or only child and have an entrepreneur in their family background (Affholder and Box 2004).

2.6.8 Barriers and constraints of female entrepreneurship

Among the principle constraints to women is the lack of previous managerial experience, business background and therefore informational needs particularly at start-up. Secondly there is still a struggle to access finance especially in terms of acquiring venture capital funding (Affholder and Box 2004). Relatively few women occupy decision-making positions in industry or finance. In addition there maybe an element of discrimination.

2.6.9 European Context

The level of female entrepreneurship in Europe remains low in relation to that of males and to the percentage of women in the population (Smallbone et al. 2000). In order to facilitate the creation of businesses by women, the EEA Member states (European Union and most European Free Trade Area countries) have taken various measures addressing issues such as start-ups, funding, training, mentoring, information/advice and networks. The European Commission has addressed the issue of female entrepreneurship within the framework of various Government policies and the private sector, multiple agency and women's business association initiatives (such as Structural Funds, the European Employment Strategy, the fourth Community Action Programme on [Equal Opportunities for Women and Men](#), the Framework Strategy on Gender Equality (2001-2005) and the 3rd Multi-annual Programme for SMEs in the European Union) and The European Network to promote Women's Entrepreneurship (WES)⁵.

⁵ The European Network to promote Women's Entrepreneurship (WES), is a network created by a Swedish initiative in October 1998. It was officially launched in June 2000. This network is composed of 16 members, from all the countries of the European Union, except Luxembourg, plus Iceland and Norway. The delegates in the network represent central national governments and institutions with the responsibility to promote female entrepreneurship. One collaborative research project undertaken with the Austrian Institute of small business research has led to reports and publications on "Good practices in the Promotion of Female Entrepreneurship" and a database on female entrepreneurship

2.6.10 European Context: numbers

Women make up half the population of Europe yet make up less than half of the businesses supported by business support organisations (Smallbone et al. 2000).

2.6.11 European Context: characteristics

A recent survey of 1,356 female entrepreneurs across 25 EU countries found that women were:

- typically educated to a tertiary educational level,
- ran a micro enterprise
- started the business before the age of 35 years,
- worked over 48 hours a week (typically 60 hours); and
- were married with children but had no help at home (Eurochambers 2004)

2.6.12 European Context: drivers, barriers and constraints

The drivers for women in Europe are similar to those of other women around the world.

Across the world many of the barriers to women entrepreneurs are similar. In Europe a recent study found that these include difficulties accessing finance particularly at the nascent start-up phase, confidence issues related to a lack of business skills and management training, limited marketing skills and training opportunities and IT skills and effective use of IT. In addition women lacked knowledge and awareness of business support providers and female specific training. Other factors included variable levels of child care availability, a prejudiced societal perception of role and responsibilities of women and unequal opportunities between men and women (Smallbone et al. 2000).

2.6.13. Female entrepreneurship in United Kingdom: context

In 2004, total employment (based on the ICSE-1993 classification) showed a total labour force of 28.01 million. 12.97 million (46%) were women and of those 0.96 million (7.4%) were categorised as 'employers and own account workers (self employed)', as compared to 2.6 million (9.2%) men. This represents 3.4% of the total workforce employment figure. However, these figures only provide an indication of the working activity, as they do not directly correlate with business start-up and ownership figures. It is therefore, likely to underestimate entrepreneurial activity

particularly amongst women and amongst women involved in family-owned businesses where co-ownership can be masked. However, the gap between male and female entrepreneurship in the UK compares poorly on the international stage. In 2001 the UK was ranked 26th out of 29 countries in terms of balance between male and female entrepreneurs. In 2003, the total female entrepreneurial activity in the UK was just 3.8% compared to men with an 8.9% rate (Harding et al. 2004).

From a study from Strathclyde University in collaboration with the National Foundation for Women Business Owners and IBM in 2001, it was found that *'Women entrepreneurs represent one of the fastest growing segments in the UK economy, ...Women entrepreneurs are creating a more gender-balanced business marketplace through a rapid increase in the number of women-owned business start-ups... despite a gap in access to capital'*. (Carter and Anderson 2001) although they have yet to obtain the same parity with female entrepreneurship as the USA. Increases in female self employment have been gradually increasing in recent years. From 2002-2003 the numbers of self employed people increased by 8.9%(282,000) compared to a 0.1% increase in employees showing growth from 24% in 1990 to 26% in 1999 when it was estimated there 824,659 self employed women rising to 108,000 to June 2004 (Carter and Anderson 2001). Self employed women now account for 6.8% of the UK's working population (GEM 2004 (Acs et al. 2005). According to the women's enterprise national body, Prowess⁶, 12 – 14% of businesses are majority owned by women. The development of the Strategic Framework for Women's Enterprise in 2003 also aims to raise awareness by setting a target that will see the proportion of businesses that are majority women owned rise from 15 to 18% to 20% by 2006 (SBS 2003). Chancellor Gordon Brown revealed that if Britain could achieve the same levels of female entrepreneurship as the USA, 750,000 more businesses would result. To further encourage this growth, increased childcare and training opportunities for women were announced as part of the 2006 Budget.

⁶ Prowess is the UK association of organisations and individuals (over 180 members) who support women to start and grow businesses, through the development of an effective women-friendly business support infrastructure and enterprise culture. We achieve this by raising awareness, providing capacity building support to organisations which provide enterprise support services and by lobbying and advocacy at national, regional, European and local levels. Prowess support 100,000 women each year to start 10,000 new businesses that contribute an additional £1.5 billion to the economy.

2.6.14 Female entrepreneurship in United Kingdom: characteristics

More women in the UK are starting-up businesses which are gradually crossing a variety of industries (Carter & Anderson 2001). Nevertheless, a gender divide is still evident with women more often than men (5.8% v 4.9%) operating businesses within sectors that have been seen as 'traditionally' female, such as socially orientated retail and service sectors) (Minniti et al. 2004). This is particularly evident when looking across four UK regions, East Midlands, London, The North East and the South East where 48% of female entrepreneurs own businesses in the service sector compared to 36% of men, tend to have smaller businesses and the start up period and processes tend to be longer (DTI 2003). In 2003, Everywoman Ltd⁷. reported that, of the estimated one million UK businesses owned by women, 11% were based in London, 35% in the South, 29% in the North and 21% in the Midlands. The highest proportion of businesses were less than 3 years old and 50% had been established in the previous 5 years. Most of the female businesses were focused in retail and whole sale (26%) and service sectors (33%)' 51% of women ran businesses from home and 70% of women had never run a business before. In addition, where women work in clusters, such as women in the business sector, female entrepreneurship gains greater strength and influence. In relation to ethnic minorities the total entrepreneurial activity rate for Black Caribbean women in the UK is 11.3%. This is higher than the average for the whole UK male population. In social enterprise and rural communities female entrepreneurial activity is higher than that of men (Harding et al. 2004)

A summary of other key characteristics identified demonstrate that:

- Women entrepreneurs in the UK tend to be younger than their male counterparts (50% women aged 16-44 versus 33% men with the remainder aged over 45 years) (Barclays Bank SME Research Team 2004).
- Women were less likely to be married than their male counterparts (60 v 69%) although they were twice as likely to be widowed, divorced or separated (Barclays Bank SME Research Team 2004).

⁷ Founded in September 1999, Everywoman Ltd launched its first service, the website www.everywoman.co.uk. It was the first interactive website for women in the UK and is now the leading online network for women starting or growing a business. With over 100,000 signed-up members, everywoman.co.uk provides users with relevant information, appropriate services and additional resources

- Women entrepreneurs were slightly more educated than men (20% of the male respondents had no qualifications compared to 12% of the women). Similarly, Carter and Anderson found that women were more likely to be educated to tertiary levels and/or have vocational qualifications. In addition, they also found that women tended to be more innovative providing a product or service unfamiliar to the market that has been developed in the last year, has fewer competitors and more likely to use modern technology in their products or services compared to their male counterparts. They were also more likely to collaborate with research institutes such as universities (11.45 compared to 3.8% of men), look for externally funded R & D collaborations. Unlike men they are less likely to collaborate with other competitors (Carter and Anderson 2001).
- Women entrepreneurs were slightly less likely to have previous experience setting up or running business (32% v 38%) but were likely to be more adventurous starting-up a business in an area they had not previously been employed (Barclays Bank SME Research Team 2004).
- Another study found that women in the UK are significantly less likely than men to think they have the skills to start a business, have or know of entrepreneurial contacts and are much more likely to fear failure, and more likely to obtain finance from friends and family and government sources, invest fewer personal resources into their business than men, less likely to apply for external finance but when they do are more likely secure funding from a range of other sources (Harding et al. 2004).
- The majority of businesses started by women employ less start-up capital, used known technology and targeted existing markets (Acs et al. 2005)

2.6.15 Female entrepreneurship in United Kingdom: drivers, barriers and constraints

Most female entrepreneurs are opportunity driven.

There are a number of common factors that present barriers for women making the transition into self-employment or social enterprise in the UK. They can be grouped into the following categories:

- Lack of business support - many women feel there is a lack of role models or women in business who are willing to mentor, support and advocate entrepreneurial activities.
- Finance and capital funding.
 - Traditional credit scoring systems can discriminate against women who tend to have a less detailed and more fragmented financial track record. There is also a failure by some lenders to understand and appreciate the differing motivations of entrepreneurs.
 - Women also own fewer assets and so have less collateral for a loan than men.
- Impact of combining family/childcare responsibilities and work
- Limited access to informal and formal business network mentors or peer support can be a major barrier for women starting new business ventures, particularly without previous experience. The ability to develop and create robust networks has been shown to have a positive effect on new business ventures and significantly improving profitability. In general men tend operate in much stronger, male networks than women. Women also do not tend to collaborate with competitors as much as men.
- Skills, self-belief, self-esteem and confidence - Women are less likely to perceive or identify themselves as entrepreneurs describing their work as entrepreneurial rather themselves as the entrepreneur. As a consequence they can underrate their performance/skills when compared to their male business-orientated counterparts. Many women state they need additional skill and training suggesting a lack of confidence in their own abilities.

The problems faced by women are compounded if they also happen to be from ethnic minorities, the members of which face similar but not identical problems to those that women as a whole encounter. However, they also have access to different resources (Walding et al 2000).

2.7. Conclusion

The development and interpretation of entrepreneurship has changed over time and expanded to recognise different types of entrepreneur such as the intrapreneur and serial entrepreneur. Also, more recently, we have seen the rise of the idea of social entrepreneurialism, and this is now being promoted to serve those areas of society

that are not being well served by the incentives inherent within the commercial sector.

Developments in healthcare (see chapter 3) mean that the entrepreneurial contribution within this sector may largely be made by NMHV's, who predominantly are female and therefore face particular obstacles to becoming entrepreneurs. Among them are a lack of confidence, limited acceptability of women starting up new enterprises, lack of networking and skills training opportunities and lack of access to finance. Many of our expert seminar participants spoke from personal experience about such constraints. However, they did not identify these as being so strongly gender related. Rather, such constraints were regarded as generic problems for people who were accustomed to working as nurses in the NHS (see Chapter 5). Many developed countries, including the UK, have established a range of organisations and policies to promote and support micro enterprise initiatives by women entrepreneurs. Nevertheless, the level of UK female entrepreneurship continues to fall behind much of Europe and the USA.

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Chapter 3 The policy context

3.1 Introduction

This chapter focuses on how UK health policy has not only enabled (or not enabled) nurse entrepreneurialism, but how nurse entrepreneurialism and innovation more generally has been promoted and represented within policy and by policy makers. First we sketch out some of the differences in health policy emphasis across the four countries of the UK as well as the influence of cross-cutting government policy on this topic, then we provide a chronology of relevant policy within a ten year period from 1996; we then provide a more focussed discussion of UK health policy and other statements and documents from the UK's Health Departments that have a direct bearing on this subject either because they set out explicitly to enable or promote nursing entrepreneurship or have the effect of doing so or have the effect of inhibiting it. The policy mapping and analysis is not an exhaustive review and includes only the policy or other statements, guidance or speeches that the research team believe are of relevance to the topic of the scoping exercise. Policy of more indirect effect, such as overall treasury policy, is considered only briefly while policy of more direct relevance, such as that enabling PCTs to commission health services from a diverse range of provider types, or policy with specific focus on nursing roles, is discussed at more length. (See also Chapter 4 and appendix to Chapter 4 for further details of various arrangements affecting primary care.)

3.2 Policy diversity in the four countries of the UK

Since 1997, devolution has led to differences in NHS structure and funding streams in the UK's four countries. It has also seen differences in patient satisfaction, waiting times and activity (Alvarez-Rosete, Bevan et al. 2005). Each country's equivalent to The NHS Plan (*Our National Health*, published in Scotland in December 2000, *Improving Health in Wales*, 2001 and *Investing in Health* published in Northern Ireland in 2000) and subsequent legislation set out different approaches to setting and working on NHS priorities. Approaches to the role of Primary Care and the degree of diversity of provision and contestability encouraged or allowed differ across the four countries. Generally, diversity of provision is far higher on the policy agenda

in England than the other countries⁸. Although *Our National Health* identified that spare capacity within the independent sector could be used to address waiting list problems within the NHS, there appear to be no long-term plans to involve the private sector to the same extent in Scotland as in England. A similar approach exists in Northern Ireland (though since the suspension of the Northern Ireland Assembly in 2002, no major changes in health policy affecting funding or the primary care sector has emerged) and in Wales (Galloway 2004). English policy differs from the other 3 countries in the degree to which it looks to increased separation of commissioning and provision of services to provide the advantages of efficiency and patient-responsiveness. This in turn may well mean that opportunities for nurse entrepreneurship around the provision of primary care services are greatest in England.

3.3 The policy context for entrepreneurialism in the UK

Overall government policy has influenced health policy in two ways. First, cross-cutting reviews have incentivised all government departments to prioritise certain goals and second, it has set the overarching context of the government's approach to enterprise and the encouragement of entrepreneurial behaviour as part of its overall social policy.

In terms of departmental targets, the Treasury set up, as part of its spending reviews, in 2002 and renewed in subsequent years, a range of performance targets for all government departments. The Department of Health was set 12 targets in 2002

⁸ In Scotland the Secretary of State for Scotland published the White Paper *Designed to Care; Renewing the National Health Service in Scotland* in the same year The Scottish Office (1997). *Designed to Care: Renewing the National Health Service in Scotland*. D. o. Health, The Stationery Office. As a result of the document *Our National Health*, published in December 2000, all NHS Trusts in Scotland were abolished. *Improving Health in Wales* was launched in February 2001 and was the equivalent of the NHS Plan in England. There are no Primary Care Trusts in Wales. Instead resources are allocated to 22 Health Boards for commissioning health care, along with Secondary Care Commissioning Groupings. Commentators believe that the role of the independent sector in providing services will be less than that in England. A similar picture exists in Scotland where 15 NHS Boards fund both primary and secondary care sectors.

concerning speed of access to various services and increased choice regarding hospital appointments as well as a number of disease focussed targets. Though some of the documented claims to have achieved such targets appear incomplete and occasionally unconvincing (see for example http://www.hm-treasury.gov.uk/performance/targets/perf_target_13.cfm), such performance monitoring clearly has had a strong influence on priorities within the department as our review will show.

Government policy has attempted to promote aspects of entrepreneurial behaviour as one element of its approach to addressing social problems such as inequality and exclusion and to add flexibility to some health and social services traditionally delivered by state agencies. In 2002 Chief Secretary to the Treasury and the Home Secretary launched the report of the Treasury's cross cutting review of the role of the voluntary and community sector in service delivery. The report set out recommendations designed to overcome the barriers facing voluntary and community organisations in delivering public services and facilitate partnerships between the Government and the voluntary and community sector. The report highlighted the potential of the contribution of social enterprise. A unified Social Enterprise Strategy was launched and the Social Enterprise Unit (SEnU) at the Department for Trade and Industry was charged to co-ordinate its implementation. Four years later, *Our health, our care, our say*, the white paper on health and social care published by the Department of Health on 30 January 2006, contained some significant commitments to social enterprise. In particular, it set out the creation of a new Social Enterprise Unit within the Department of Health and indicated that a fund would be set up to '... provide advice to social entrepreneurs who want to develop new models to deliver health and social care services. This fund will also address the problems of start-up, as well as current barriers to entry around access to finance, risk and skills, to develop viable business models. support people developing new social enterprises delivery models.' (Department of Health 2006). This initiative was welcomed by the Social Enterprise Coalition, a body which promotes social enterprise in the UK. This move can also be understood as following from a wider cross government policy agenda for the public services coherent with development of ideas which began in New Public Management (McLaughlin, Osborne, & Ferlie 2002) for the incorporation of private sector ideas and methods in public services common to many other European countries (Saltman, Busse, & Mossialos 2002).

3.4 Selective chronology of key health policy and events relevant to N M HV entrepreneurs and patient choice

Table 5.1.

1997	<p>The New NHS, Modern, Dependable (Department of Health 1997) published in England sets out the need for more flexible professional roles and ways of working within the NHS</p> <p>The NHS (Primary Care Act) 1997</p> <p>Introduction of flexibility through : 1. Salaried GP 2. Primary medical services (PMS) contracts between practices and HA to improve personal medical services within case limited GMS budget, 3. PMS plus contracts to extend the PMS pilots to cover personal medical services and a range of other services under a combined GMS/HCHS budget and salaried GPs</p> <p>GP fund-holding is suspended but the purchaser-provider split is retained</p>
1998	<p>NHS Direct is launched in England.</p> <p>The Department of Health published “Our Healthier Nation. A Contract for Health”, Cm. 3852; the Scottish Home and Health Department published “Working Together for a Healthier Scotland”, Cm. 3854 (and see 1999); and the Welsh Office “Better Health. Better Wales”, Cm. 3922. The English document set health targets for the next ten years; and acknowledging the influence of adverse social, economic and environmental factors as causes of ill-health, promised action across government departments to tackle poor housing, low wages, unemployment, crime and air pollution.</p>
1999	<p>1999 Health Act (in England) (c.8) proposed the replacement of the fundholding scheme introduced in 1990 by primary care groups, each group to cover a population of about 100,000; the establishment of a Commission for Health Improvement to provide independent scrutiny of the standards of clinical care; made provision for payments between health service bodies and local authorities; and conferred powers to regulate any profession concerned with the physical or mental health of individuals. Part II of the act dealt with changes to the NHS in Scotland.</p> <p>Primary Care Groups introduced in England on April 1st. 92 first wave PMS pilots launched. Changing policy about the presence of nurses on the boards of directors of these and successor bodies.</p>

	<p>The Secretary of State for Health (England) announced the opening of Walk-in NHS Centres. In most cases the care available would be given by a nurse. The BMA called for the clinics to be run as pilot schemes and for their work to be evaluated.</p> <p><i>Making a Difference strengthening the Nursing, Midwifery & Health Visiting contribution to health and healthcare</i> (1999) Making a Difference (DoH 1999) New nursing strategy, 10 key roles for nurses. Plans for nurse consultants first outlined.</p>
2000	<p>The NHS Plan: A plan for investment, a plan for reform. Health service reform continues with continued emphasis on flexible N M HV roles.</p> <p>The first wave of PCTs go live. Independent Nurse prescribers permitted to prescribed from a limited formulary.</p>
2002	<p>Delivering the NHS Plan; next steps on investment, next steps on reform Primary Care Trusts to be free to purchase care from the most appropriate provider, public, private or voluntary. Financial flows to change, cash for treatment to follow patients to enable choice of provider.</p>
2003	<p>Building on the Best. Choice, Responsiveness and Equity in the NHS (Department of Health 2003) (in England). This document set out how the Government intended to make NHS services more responsive to patients, by offering more choice across the spectrum of healthcare. Its main aim was to improve patient and user experience and build new partnerships between those who use health and social care and those who work in them; a wider role for nurses to treat more conditions</p>
2004	<p>Putting People at the Heart of Public Services: The NHS Improvement Plan (Department of Health 2004) choice of hospital and other provider high on its agenda with use of private facilities possible in order to achieve this.</p> <p>New PMS contract agreed. From April 1st PMS arrangements change increasing the flexibility of PMS.</p> <p>Additional contractual mechanisms beyond nGMs and PMS guidance produced and change of statutory direction made:</p> <ul style="list-style-type: none"> - Specialist PMS providers (new model within PMS not expected to deliver totality of essential PCMS) - Alternative primary medical services (APMS)

	- Primary Care Trust Medical Services (PCTMS) contracts
2005	<p>Commissioning a patient-led NHS This document follows on from the publication of <i>Creating a patient-led NHS</i> in March 2005 and focuses on how the Department of Health will develop commissioning throughout the NHS, with some changes in function for PCTs and SHAs.</p> <p>The Third Sector commission taskforce set up.</p> <p>Sir Nigel Crisp's letter of 28 July 2005 Commissioning a patient led NHS: The future of PCTs and SHA</p>
2006	<p>Our Health, Our Care, Our Say (Department of Health 2006). This continues the work on patient choice and sets out mechanisms for delivering more personalised. health services. It sets out some nurse-led innovative services and various measures to encourage social enterprise to engage with the delivery of health and social services.</p>

3.5 Overall policy priorities for the NHS since 1997 and New Labour

We first consider the thrust of UK health policy as setting the context and preparing the way for the subsequent emergence of the promotion of N M HV entrepreneurialism. The promotion of innovation has been one prominent way that this context has been set and nursing has been a particular target for this message.

3.5.1 Reducing waiting lists and increasing throughput

New Labour was elected in 1997 with pledges to dismantle the internal market and spend the savings on reducing waiting lists. By December of that year *The New NHS, Modern, Dependable* (Department of Health 1997) was published adding the establishment of national standards of treatment and a programme of NHS modernisation to this ambition.

3.5.2 'Modernisation': breaking professional demarcations leading to 'innovative ways of working'

In this and subsequent policy, 'modernisation' is presented as the development of more flexible ways of working both in terms of hours and roles and becomes a central feature in subsequent policy and innovation is explicitly encouraged.

The NHS Plan (July 2000) and *Making a Difference strengthening the Nursing, Midwifery & Health Visiting contribution to health and healthcare* (1999) set out changes that are said to have 'put nurses at the heart of the modernisation agenda'. 'Old' demarcations, and the rigid ways of thinking that the NHS Plan associates with them, are described as preventing nurses from achieving their potential. If nurses were and continue to be given prominence, it could be because the government had learned that doctors have been among the fiercest resisters of such 'modernisation' if it means submitting to increasing managerial control (Munro 2002). Other initiatives and legislation such as the New Deal for Junior Doctors in 1991, and the European Working Time Directive (EWTD) which came into effect for doctors in training in August 2004 have also acted, subsequently, as drivers for nurses to move into previously medical roles. Aspirations for greater professional status may well also add to the attractiveness of taking on such roles, with certain activities such as prescribing having particular symbolic function. In addition nurses publicly identify with the humanity and quality of the patient experience (McTavish 2003) (Chapple, Macdonald et al. 1999) and might be expected to initiate or participate in initiatives that may improve this.

'Modernisation' presents certain organisational advantages because breaking down traditional demarcation can make patient flows more efficient and play a part in managing demand for highly stretched parts of the service. For example, the nurse-led NHS Direct is described as diverting demand from conventional NHS services. The CNO's new 10 roles for nurses, included in the NHS Plan, feature organisational/administrative roles alongside clinical roles e.g. ordering tests, managing caseloads, prescribing drugs. In 2000 and 2001 when patient waiting lists, and their manipulation by some trusts were a high profile political problem (Carvel and Allison 2001), *The NHS Plan CNO's message to nurses* (March 2001) emphasises that new nursing roles can improve patients' journeys through the healthcare system. Nurses can reduce waiting and aid access to the system by providing additional points of access.

3.5.3 'Patient choice'

Patient choice has come to the fore of the government's priorities for the NHS. According to the NHS Confederation, policy priorities since *The NHS Plan* can be

seen in terms of two phases⁹. From 2003-6 these feature improving access and reducing waiting, and from 2004-8 this shifts to increasing patient choice, and the range of providers (Miles 2005).

People will be able to access primary care services in more flexible ways such as walk in centres at train stations or football stadiums. Primary care practices will be able to offer a wider range of services such as diagnostics.

(<http://www.dh.gov.uk/PolicyAndGuidance/PatientChoice/Choice/fs/en>)

Building on the Best: Choice, Responsiveness and Equity in the NHS was published in 2003. This set out the intention to offer patients choice at the time their GP refers them for treatment. By offering choice at this point, patients would be given the chance to choose the hospital that best suited their needs. A £65 million contract to provide all GPs with the ability to make outpatient appointments electronically would facilitate this (Rivett 2006). However this kind of choice could lead to the problem of ensuring that financial limits were not exceeded at a local level. In addition, it would be managers and clinicians who would retain control of how far patients would be offered new options, and, crucially, the capacity of the NHS to provide services might constrain choice for practical reasons. Nevertheless, as part of the NHS Improvement Plan, PCTs were instructed to offer their patients four or five choices regarding where they might receive treatment and that private/independent care should feature amongst these. The publication of A Patient-led NHS in March 2005 allowed independent providers such as BUPA to be included within the list of choices. The paper also proposed that there might be regional or national contracts with providers to reduce the transaction costs of multiple contracts. This arrangement was implemented in January 2006. However, choice presents problems: 'It was possible that patients would increasingly choose private sector hospitals. Many people thought they were cleaner, better managed, had shorter

⁹ In some specific areas of health care this policy agenda on increasing user choice has a longer history. 'Choice' along with continuity of care(r) and control and has been a central theme in maternity care policy from the early 1990s (Department of Health 1993). Such policy had been influenced by a decade or more of campaigning by user groups such as the AIMS and the National Childbirth Trust and by midwifery organisations like the Association of Radical Midwives to offer 'woman-centred' alternatives to the bio-medical model of maternity midwifery care (Leap 1996).

waiting times and provided better facilities. If money followed into private hospitals, there was a substantial threat to the budget of NHS ones' (Rivett 2006).

Patient choice is also presented as the driver for flexibility and innovation in *The NHS Improvement plan* (2004) which claims that 'front-line' staff are being incentivised to be 'innovative and creative'. 'A new spirit of innovation has emerged', claims John Reid in the Foreword. Though much of the claiming about progress is focussed on reduced waiting times, access and choice are also emphasised. 'Working flexibly' is connected to 'responding to patients' needs'. Patient choice is described in terms of 'personalised care' and choice of different providers and, from 2008, this can include non-NHS providers. This is said to help with both capacity problems and choice: 'Patient choice will be the key driver of the system.' The practice nurse, NHS Direct and Walk-in Centres are seen as the elements of choice that a patient may have as alternatives to making an appointment to see a GP and the new Community Matrons (discussed on page 41 of that document) will manage the cases of people with complex needs.

Despite this promotion, a recent review has found that choice is not a high priority for many NHS patients, partly because to date there has been little real opportunity for the exercise of choice (Fotaki, Boyd et al. 2005).

3.6 Changes in primary care

3.6.1 PMS Pilots

The unanticipated interest in GP fundholding, introduced as a mechanism of the internal market in the early 1990s, has shown governments the potential of primary care to lead aspects of NHS reform. It is in this sector that policy can be understood as explicitly enabling entrepreneurial activity. The 1999 Personal Medical Service pilots were presented by the Chief Nursing Officer (Department of Health 1999) as innovative and sometimes status-reversing examples of new forms of provision in this sector. Each of the examples given in *Making a difference, strengthening the nursing, midwifery and health visiting contribution to health and healthcare* is linked in the document with some improvement for patients. These innovations took the form of either role substitution or the provision of services to previously neglected groups e.g. pregnant drug users (Department of Health 1999).

3.6.2 How policy reframes and promotes desirable qualities in the nursing workforce

In 2000, the Chief Nursing Officer published *Making a difference in Primary Care: case studies*. Many, if not all, of the case studies chosen emphasise personal features of nurses virtually identical to those said to characterise social entrepreneurs (see Chapter 3): risk taking, networking, tenacity, vision, working with particular (often disadvantaged) communities, seeing a need for grass roots action, having to argue for resources and funding. These individuals are different, however, from most conceptions of social entrepreneurs in that they are still enmeshed in bureaucratic NHS structures and there is sometimes, according to their own accounts, tension between this and their innovative work. (Though such 'intrapreneurship' is a widely-discussed concept often promoted as an aid to organisational innovation. See Pinchot (1985)).

3.6.3 The focus on primary care: contestability and confusion

Primary Care Trusts, which were established in April 2000 succeeded Primary Care Groups and were given significant responsibilities and budget (80% of the NHS budget (Department of Health 2004)) to commission services for their localities (see also Chapter 6). Since their creation, and direct allocation of budgets in 2002, they have been increasingly encouraged to diversify their commissioning of care into the voluntary and independent sectors. *The NHS Improvement Plan: Putting people at the heart of Public Services* enabled PCTs to commission services from a wider range of providers with a target of 15% of services provided from the independent sector. Opening up diversity of provider, including the private sector, for NHS patients was originally looked to as a way of meeting ambitious waiting list targets without having to first develop capacity within the NHS itself, which would clearly take time. However, subsequent policy appeared to go a step further. 'The involvement of the private sector, having started out as a short-term necessity, is now regarded as a policy end in its own right. As the Department of Health has stated: 'It is an explicit objective of government health policy to shift towards greater plurality and diversity in the delivery of elective services' (Lewis 2002). In fact, diversity of provider, funding source and of service design has been promoted as a mechanism for increasing choice (Department of Health 2000; Department of Health 2003; Department of Health 2004). Fotaki and colleagues claim that while there may not be strong demand from patients for choice, from the policy maker's point of view, the introduction of choice may have other attractions, for example as a means of

introducing contestability into a service with the presumed effect of focussing providers more on quality of service issues (Fotaki, Boyd et al. 2005).

During the scoping the question of the future of PCTs as providers of primary care services became a policy controversy. In March 2005, the Department of Health introduced a policy reform detailed in *Creating a Patient led NHS, and Delivering the NHS improvement plan*. Among its proposals were plans to encourage the primary and community sector to develop new services and practices. On the 28 July, Sir Nigel Crisp, published a letter to NHS Chief Executives and PCT chairs which set out the impact that these reforms would have on commissioning of services within the NHS.

As PCTs focus on promoting health and commissioning services, arrangements should be made to secure services from a range of providers – rather than just through direct provision by the PCT. This will bring a degree of contestability to community-based services, with a greater variety of service offerings and responsiveness to patient needs. ...the direction of travel is clear: PCTs will become patient-led and commissioning-led organisations with their role in provision reduced to a minimum. We would expect all changes to be completed by the end of 2008. (Crisp 2005)page 3-4)

As one step along this direction of travel, a national scheme launched in July 2005, The Innovation in Primary Care Contracting programme, incentivises the uptake of APMS (Alternative Provider Medical Services) contracts on the part of PCTs. PCTs are to be supported to engage in contracts with alternative service providers in order to offer previously unsupplied services within particular, often deprived, communities. The scheme provides legal and other support to encourage contracting with new types of organization or to develop new types of contract with 'entrepreneurial GPs and other primary care providers, including those from the independent and voluntary sectors'. In the next chapter we introduce a model developed by Burchardt and colleagues which has been used to categorise the various combinations of ways that healthcare services can be commissioned, provided and delivered.

Responses from the nursing profession to the changes in primary care have been mixed. While the RCN has campaigned against this change on the grounds that it would fragment patient care services and lead to adverse selection and other ethical problems associated with private provision, news articles have featured some stories

of the formation of nurse led independent service providers as generally positive examples of nurses' entrepreneurial abilities (Nursing Standard 2005). Fotaki and colleagues also caution that the introduction of choice policies can, when combined with greater access to performance data, have hidden adverse effects on equity as, for example, providers may try to avoid treating high-risk, sicker patients in order to improve their own performance figures. One of the knowledge gaps they identify is whether choice policy actually does lead to contestability in the long run and what conditions best facilitate it.

3.6.4 New nursing roles: new nursing flexibility

One explicit linking of new expectations of nursing roles with the concept of entrepreneurialism came in the form of then Health Secretary, John Reid's, first address to the Chief Nursing Officer's conference in November 2003. It is considered here because its argument in favour of flexible healthcare roles in terms of entrepreneurialism and its association with patient choice can be seen as representing the blurring of these two ideas in health policy as a whole. The press release (Department of Health 2003) and the full text (The Guardian 2003) of the speech mixes together a number of ideas: that recent policy has added new opportunities for nurses; nurses as doctor substitutes/ advanced practitioners /taking new skills; nurses as autonomous practitioners; nurses not confined by role; nurses as risk takers (though there is internal contradiction with clinical governance and other parallel policy initiatives); nurses are close to patients; and patient choice is high on the NHS agenda. Entrepreneurs are defined as risk-takers and innovators but no examples are given of nurses in risk-taking roles, rather it is a picture of nursing as responding to the needs of individual patients and later, in substituted roles, that is provided. That these themes are drawn together more by association than by clear argument suggests a possible lack of clarity and precision about government promotion of entrepreneurialism in nursing but can be seen as an example of the positive associations of the term entrepreneurial being used to encourage nurses to be more receptive to organisational and role flexibility, a major aim of health policy at the time. This particular speech also draws attention to the recent policy emphasis on patient choice. Nurses and midwives are described as playing a vital role in promoting choice, however, this is through substitution rather than entrepreneurial ventures. The example given, as with most of the policy documents reviewed, concerns the increased ease in patient pathway that can result

from increased role flexibility, in this case it is the substitution of nurse prescribers for doctors

The CNO's December 2003/January 2004 Bulletin features her response to John Reid's speech. Already it is clear that the term entrepreneur at times stands in as a synonym for innovator and partly does duty to re-emphasise extended roles or role substitution (the example given again is nurse prescribing). The published CNO's response echoes the need for initiative and problem solving among nurses. In summary, the speech and response from the CNO appear at face value as important statements aimed at encouraging and enabling nurse entrepreneurship, but their content can be more easily understood as reinforcing the already existing policy to do with the creation of a more flexible NHS workforce and the breaking down of traditional professional boundaries.

Given the promotion of new roles for nurses by the Department of Health as symbolic and status-enhancing, it is not surprising that some opposition has been voiced within medicine. Although generally, that profession appeared to have acquiesced to the establishment and gradual expansion of nurse prescribing, one response from Richard Horton in the Lancet in 2002 can be seen as both contributing to professional protectionism and articulating insightful political analysis:

"the UK will be embarking on a dangerous uncontrolled experiment...Nurses are being manipulated, under the guise of providing quicker and more efficient access to health care to fill the gaps left by too few doctors... Prescribing is not a major advance in professional status for nurses. It is merely redrawing the boundaries of a profession to serve an acute political problem, with little regard for the impact it will have either on nursing or the care of patients." (The Guardian 2002)

3.7 Other policy strands

Other strands of policy where there is a link between entrepreneurialism and choice are found within policy concerning midwifery, though their history is longer and found a particular articulation in Changing Childbirth. The Independent Midwives Association (IMA)'s NHS Community Midwifery Model, currently being considered by the Department of Health, provides an example of an alternative model of care to that which is traditionally provided (the model is outlined in full on the IMA's website www.independentmidwives.org.uk). Under this model of care the pregnant women

chooses a midwife from a list of local practitioners and during the course of the pregnancy builds a relationship with her. The midwife would have access to NHS facilities so her client could choose the place and type of birth that most suits the woman's needs. It is proposed by the IMA that this model sit alongside current provision and be available to any midwife interested in working this way and to women who want continuity of care.

A number of other policy initiatives have addressed health inequalities that has encouraged entrepreneurial activity around service provision to previously unserved or underserved groups. Often the intention has been that entrepreneurial activity would promote equity and increase access by extending choice beyond those sections of the population who are well off or articulate. There are social programmes which address inequalities in 'collectivities' or communities such as the development of Sure Start and children's centres and Healthy Cities and Health Action Zones. In terms of policy, Sang (2004) believes policy on choice has presented the opportunity to rethink roles and contributions in relation to health services and to understand the purpose of social and 'civic' entrepreneurs as challenging health inequalities (2004: 188). However, such policy also, perhaps necessarily, raises other questions (many articulated by Fotaki and colleagues 2005) such as: how does improved equity and access fit with greater organisational effectiveness and efficiency? Will some patients continue to be able to make 'better' choices than others because of education, income or social position? Oliver and Evans (2006) argue that there is little safeguard at present against this risk. On the other hand, there are examples of where social entrepreneurship can encourage community involvement in health care by presenting the opportunity for increased local democracy and democracy in health (Fawcett & South 2005).

3.8 Conclusion: Policy linking NMHV's, entrepreneurialism and patient choice

Policy since 2001 has emphasised patient choice as a priority value within the NHS. It has encouraged innovation and entrepreneurialism as likely to promote patient choice within, and on the edges of, the NHS. Recent, accelerating and sometimes apparently unconsidered changes to primary care services have attempted to promote diversity of provider. Within changes already implemented there are some examples of NMHV's acting entrepreneurially by providing services to PCTs previously provided within the NHS (e.g. (Nursing Standard 2005); (Houghton 2002)) though it is not clear that these initiatives necessarily promote patient choice.

A second way that entrepreneurialism has appeared in policy is as a synonym for innovation as part of the promotion of desirable qualities, which may be termed broadly intrapreneurial, within the NMHV workforce. Mr Reid's speech, discussed above, and earlier documents encourage NMHVs to move away from stereotypical roles which are said to feature passivity, a rule-bound mentality and subservience to doctors. Such talk can raise energy levels and have an effect on culture and consciousness among NMHVs, quite apart from any enabling policy or organisational changes. However, certain initiatives such as nurse prescribing and NHS Direct show that this kind of policy coupled with any necessary legislative change has the potential to address issues of organisational efficiency and demand for NHS services and at the same time be generally attractive to the NMHV professions, though, predictably perhaps, less appealing to doctors in specific cases.

Finally different possible scenarios of the contribution that entrepreneurial activity can make to patient choice emerge from this review:

- Alternative providers
- Organisation effectiveness
- Different models of care
- Increased service provision to unserved or underserved groups

In the next chapter we detail and provide categorisations of NMHV entrepreneurial activity.

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Chapter 4 Nurses, Midwives, Health Visitors and Entrepreneurship: the evidence

4.1 Introduction

This chapter considers the evidence firstly from the international then the UK perspective. In each of these sections, we consider

- Specific evidence of the extent and types of entrepreneurship by nurses, midwives and health visitors
- Evidence of the circumstances, triggers, aspirations and barriers to the different types of entrepreneurship by nurses, midwives and health visitors
- Evidence of outcome and consequences of entrepreneurship by nurses, midwives and health visitors

This scoping study has examined a wide range of literature. Before discussing this in detail, a number of issues need to be raised about the nature of this literature. It should be first noted that the international empirically based literature on this topic is very small suggesting that many aspects have not been objectively examined. The narrative and descriptive accounts by entrepreneurial nurses are more common but not extensive. In part this is a result of the nature of the entrepreneurial person and how s/he views himself, as pointed out by members of the expert seminar; “We *‘do’*: *we don’t write it up* “. It should be noted however that some narrative accounts can also be read as a marketing or promotion exercise as do some of the journalist written and feature articles. Individual websites while they may feature a range of items e.g. career history, are also primarily for marketing of the nurse entrepreneurs services. It is also noticeable that some accounts, particularly those by journalists, are presented as a ‘hero’ type story i.e. the individual setting out against great challenges, where no one of the same group has gone, and reporting back success and path finding for others. Like hero stories, these can be read as seeking to inspire others and they do not recount failure. These accounts related to entrepreneurial activities of NMHV mostly present elements of the journey, rather than the end point of return to tell the whole story.

An additional challenge presents itself in reading the international literature related to nurses and midwives: not only are there a variety of interpretations of the noun,

'*entrepreneur*' and adverb, '*entrepreneurial*', across and within different cultures as noted in Chapter 3 but the term '*nurse entrepreneur*' has been defined in different ways. For example, the International Council of Nursing (a federation of 130 national nurses' associations) states that the definition of nurse entrepreneur is '*a proprietor of a business that offers nursing services*' Sanders (2003 p.4) while other nursing organisations offer statements such as '*nurse control of practice and patient care*' (Riesch 1992). In addition to this variety, there are some terms related to nurses that have different interpretations according to the specific country and health system. These include, '*Independent Nurse*', '*Independent midwife*', '*Independent Practice Nurse*' and '*Private Practice Nurse*'. The term '*Independent nurse*' in many countries such as Norway, New Zealand, Australia and the USA refers to self-employed nurses, as does the term '*independent midwife*' in the UK. However, the term '*independent nurse*' is also used to refer to behaviours associated with autonomy and self governance while working within a public health system e.g. in the UK independent nurse prescribers practice within the public health sector as employees. The term '*Independent Sector Nurse*' translated from the German refers exclusively to self employed nurses. In the United States the term '*Independent Nurse Contractor*' is used to denote 'nurses who practice outside the customary role of employee' electing to contract and negotiate directly with healthcare facilities such as hospital, nursing homes, Doctor's offices and yet still provide clinical care. Equally these nurse contractors elect how they will work as sole proprietors, limited liability companies, or in partnerships using a variety of legal entities [online at] <http://www.independentnrcntractor.com/>). However in the UK this term is not exclusive to self employed nurses but also includes nurses employed outside of the NHS in private hospitals, hospices and care homes. '*Private Practice Nurse*' is a term used the USA to specifically describe nurses employed in doctors' private practice offices, while in Australia it refers to self employed nurses offering clinical specialist skills. Bearing these caveats in mind, we now turn to the evidence from the scoping exercise.

4.2 Overview of the literature examined

Of 462 articles initially identified from our electronic and hand searches, 143 met the inclusion criteria (see chapter 1). A total of 104 published papers described UK entrepreneurial activity among NMHVs. Beyond this was an additional grey literature. As just one illustrative example, we found 119 articles dealing with UK entrepreneurial activity among NMHVs in primary care settings alone.

The electronic scoping resulted in 38 responses. No additional evaluative literature was identified but respondents supplied additional accounts from 21 independent nurse and midwifery consultancies, 4 acute care sector setting and 3 primary care setting nurse-led 'intrapreneurial' initiatives.

4.3 The International Perspective

Different healthcare systems and changes in the healthcare environment create different opportunities for nurse intra- and entre-preneurship. It is noted that internationally there is a wide range of intrapreneurial activities by nurses as indicated by the ICN The Nurse Innovations Database [Online at] <http://www.icn.ch/innovations/> launched in May 2005 to encourage and support the global dissemination of ideas. Within the scope of this review it has not been possible to investigate intrapreneurialism internationally and this section focuses on self employed or business owners.

4.3.1 The extent of nurse and midwifery entrepreneurs internationally

The International Council of Nursing estimates that in general 0.5-1% of registered practicing nurses are nurse entrepreneurs (Sanders, 2003) although no supporting evidence is cited. It is difficult to establish with any accuracy the number or trajectory of growth of nurses acting entrepreneurially either within or outside of health care organizations. The reasons include: the variety of definitions (as noted above and in Chapter 2), the lack of regulatory frameworks in all countries establishing the criteria for the use of the title nurse or nurse midwife, the inconsistent data collection/monitoring of nurses and midwives and their activities. The following provides an overview of evidence for the extent of nurse entrepreneurs, identified through the database search and the web based search of public access International and National Nursing Organizations. This provides a limited view and it is suggested that a more accurate picture would only be obtained by systematically investigating within each country /region and with the support of nursing organizations and government offices concerned with health systems.

The USA has a health care system where nurse entrepreneurs might be expected to be found in large numbers. While 2.8 million nurses are registered to practice there is little information from any of the professional nursing organizations. An independent association, the National Nurses in Business Association (NNBA) estimate that across all the states there are approximately 5000 (0.18%) registered practicing

nurses, who are self-employed [online at <http://www.nnba.net/>]. A range of areas of activity, that are by no means exhaustive, are illustrated that include: Ambulatory care, Cardiac Rehabilitation, Case Management, Nephrology, Travel Health, Education and Training, Forensics, Genetic Counseling, Infection Control etc. Other exemplars documented in the literature include; Nurse consultation services (Porter-O'Grady, 2001; Schulmeister, 1999) RN First assistant practice (DeFrancesco, 2004), Specialist Addiction Outreach Service (unnamed, 1999), Independent nurse practitioners in orthopaedic care, private nursing and education (Elabdi, 1996), Advanced practice nurse-owned Community Wellness centre (Bartel & Buturusis, 2000) and Perinatal home care service (Eaton, 1994).

- The ICN focused on self-employed nurses as part of a recent Workforce Report (ICN Workforce Report 2005). It noted from the nine contributing nursing associations that the numbers were very small, giving the following specific examples:
- Germany - approximately 800 nurse business owners (mainly of community nursing services) are represented by the Der Deutsche Berufsverband für Pflegeberufe (DBfK) (German Nurses Association). In addition, the association reports the provision of business counselling services to an unspecified number of other nurses who choose to work independently
- New Zealand - the New Zealand Nurses Organisation estimate that 50 (0.1%) of the total number of registered working nurses are practicing independently, with the largest group being occupational health nurses.
- Norway- the Norwegian Nurses Association identified that an 'increasing number of nurses who have their own business enterprises selling nursing services', however the number is unspecified.

The ICN estimates that in France 15% of working registered nurses practice in a self employed capacity. This is in part due to the historical legal protection of the *Infirmiere Liberale Francaise* (independent nurse contractors who provide clinical care principally in the home). It is noted that under French legislation other nurse-owned businesses such as nurse consultancies or nursing workforce providers are not recognized as nursing practices therefore it is suggested that the numbers of independent nurses (nurse entrepreneurs), could be much higher (Sanders, 2003).

The available information on midwives would also suggest variation in different health care systems. For example, self employment is common in the maternity care workforce in the Netherlands. Statistics from the Ministry of Health for Jan 2004 indicate that at that time there were 1,940 active midwives of whom 64% were working in their own practices - the majority of these in group practices. (Poorter 2005). Likewise in New Zealand, there are greater numbers of self employed midwives with ½ the total number of midwives being self-employed and ½ employed (New Zealand College of Midwives, see <http://www.midwife.org.nz/>). The total number of active midwives in New Zealand is 3,780 (New Zealand Health Workforce Statistics 2004 www.nzhis.govt.nz/stats/nursestats). However, the numbers of self-employed midwives in Australia are small. There are 60 although not all of these midwives have a full-time practice (personal correspondence with Robinson, an Independent Midwife Practitioner, the National Coordinator Australian Society of Independent Midwives, www.midwiferyeducation.com.au).

In developing countries, most of the more detailed studies concerned with private sector healthcare provision relate to the activities of doctors. Far less is documented about the extent of entrepreneurial activity among other healthcare practitioners such as nurse-midwives. Even in a country with relatively sophisticated data sources such as South Africa, the number and distribution of nurses working in the private sector is hard to ascertain as the South African Nursing Council does not collect this information (MacDonagh, Murray & Ensor 2003). However, some small-scale exploratory studies and evaluations indicate that independent nursing and maternity 'homes' or practices also exist in many settings in Africa: including Ghana (McGinn 1990, Obuobi et al 1999), Uganda (Seiber & Robinson-Miller 2004), Kenya (Yumkella & Githiori, 2000), Tanzania (Rolfe et al undated), as well as in the Phillipines (John Snow Inc 2005) and in Indonesia (Geefhuysen 1999).

4.3.2 Other indicators of NMHV entrepreneurial activity

Another indicator of the level of nursing and midwifery entrepreneurs is the level of support from national nursing organizations, nurse entrepreneur networks and education courses/curriculum for nurse entrepreneurship.

We have identified guidance publications from the ICN and three national nursing organizations, including the UK (see section 4.4). The International Council of Nurses published Guidelines on the 'Nurse Entre/Intrapreneur providing Nursing Service' in 1994 and updated this in 2003 (Sanders, 2003). It provides an overview of the types

of entrepreneurial practice and gives specific advice on roles, legal, economic and ethical issues to nurse entrepreneurs providing direct nursing services. It also advocates that national Nursing Associations should play a significant role in the development and regulation of NE's. *The Canadian Nurses Association* published a short paper entitled 'On Your Own – The Nurse Entrepreneur' (CAN Canadian Nurses Association, 1996). This paper provided a resource for Canadian nurses wishing to pursue entrepreneurial nursing practices describing the processes, professional and business considerations that would be required in Canada. The *Sigma Theta Tau International, Honor Society of Nursing in the USA*, published one paper providing advice and information for nurses considering moving from traditional patient care to a career as an entrepreneur (Hieronymous & Geil, 2006).

We have been able to identify networks specifically for nurses in enterprise in 3 countries, including the UK (see section 4.4) and one for independent midwives in developing countries. In Australia *Nurses in Business* is a members only network formed within the Royal College of Nursing, Australia (numbers unknown). In the USA we have identified 3 online national networks:

- *The National Nurses in Business Association, Inc* founded in 1985. This is a membership organization that provides information and creates new career opportunities for nurses working within intra- and entrepreneurial frameworks. It provides a range of educational, support and networking opportunities, conducts and monitors research related to nurse entrepreneurial activity and has established a nationwide database of nurse entrepreneurial activities.
<http://www.nnba.net>
- *The National Association of Independent Nurses*, was founded in 2002. This is also a membership organization. It represents the collective interests of independent contractors/independent nurses in business as opposed to nurse employees in traditional settings. It provides access to training materials and seminars, expert business advice and a members only chat room.
<http://www.independentrn.com/>
- *The Nurse Entrepreneur Network*, was launched in 2004 by a nurse/lifestyle coach. It is also membership organisation and offers an online facility for nurses to help other nurses build successful nursing businesses. It provides networking, educational training and coaching opportunities and assists nurse entrepreneurs in forming collaborative alliances and promoting their services

to each other and the general public <http://www.nurse-entrepreneur-network.com> .

An additional American source of advice and support that also provides online consultations on range of legal and professional issues for would-be entrepreneurs, is the *Nurses' Medscape Website* at <http://www.medscape.com>. PSP-One, funded by USAID, similarly runs a *Midwives Exchange* for midwives in private and Independent Practice in developing countries, which aims to assist independent midwives to 'strengthen your practices, share your experiences, and learn what others are doing that works well', At <http://www.psp-one.com/section/technicalareas/quality/midwives>. Pre-conference workshops aimed at improving private midwives' entrepreneurial skills in developing countries have also been held at The International Confederation of Midwives' Triennial Congress (Mantz 2005)

In the USA (and England see 4.4.) we have been able to identify educational courses for nurses addressing entrepreneurship. The Health Science Centre at the University of Tennessee is one example, using the concept of "*nursepreneurs*" in its curriculum for advanced practice. It uses practicums (clinical training experiences) in entrepreneurial settings e.g. the College of Nursing-owned Primary Care Practice enterprises, to model and teach relevant skills. The University cite individuals that go onto to develop and start-up other nurse owned nurse managed businesses and collaborative partnerships (University of Tennessee 2005)

4.3.3 International evidence for the drivers, triggers, aspirations and barriers to entrepreneurial activity by NMHV

The wider literature on women and entrepreneurialism identifies that business opportunities and necessity are key reasons for undertaking entrepreneurial activity, accompanied by triggering factors such as the push and/or pull of personal, work and environmental circumstances (see Chapter 2). There are few international empirical studies of nurse entrepreneurs with which to compare. We identified only six non UK empirical studies focusing specifically on the motives and circumstances of NMHV entrepreneurial activity (the UK studies are reported in section 4.4) . One of these was reported with very little detail making it difficult to assess its contribution (*Amundsen et al 2004*). Another reported the preliminary testing of a new conceptual scale 'entrepreneurial opportunity recognition' with 128 members of the American National Nurses in Business Association (*McCline et al 2000*) and suggested that the

focus on entrepreneurial attitudes rather than traits allowed the entrepreneurial act to be contingent on the situation and the individual. .

The third study was from Tanzania. A recent 9-district study in Tanzania (*Rolfe et al undated*) identified retirement from public sector employment and fear of a slide into poverty as a major 'push' factor for the setting up of private nursing and maternity homes. 'Pull' factors are complex and include hoped-for economic rewards, flexible working hours, a sense of autonomy, the desire to use one's talents and 'not sit idle, satisfaction in meeting the needs of underserved communities and the desire to maintain social standing through a professional identity.

Two of the studies came from Australia. Harris (2000) reports on independent midwifery and homebirth. In a trajectory similar to that of maternity care in the UK, the medical model has come to dominate maternity care in Australia and independent midwifery to be seen as a challenge to the ways of working of the current system. The particular barriers to independent practice reported are the increase in the cost of professional indemnity (see also Robertson, 2002), the lack of government funding for midwifery care, and the lack of financially viable training opportunities. Wilson's survey of 54 private practice nurses identifies that important drivers included: job satisfaction, being able to use distinctive skills, making a difference to patient care, enabling a return to nursing in line with other life activities. They were reported not to have been pushed into private practice because they were unemployable, unable to find work or redundant. It was reported that private practice offered a better prospect than hospital based work in this setting as they placed value on autonomy, increased personal and work flexibility (Wilson et al 2003, 2004).

The last study is a U.S. study based on interviews with 4 nurse entrepreneurs (Roggenkamp and White 1998) which identifies personal motivating factors as including financial rewards as well as freedom and flexibility. Instigating factors included 'the nurses' love of their particular field of nursing'. Identified barriers included a lack of business skills.

Similarly a literature review of the types, advantages, barriers and implications of clinical nurse specialist entrepreneurs (with unspecified dates, inclusion criteria and countries) concluded that the key advantages were reported as flexibility and freedom to focus on personal interests, quality and variety of work. The reported disadvantages included the higher cost of malpractice insurance, lack of hospital privileges, professional scepticism, start up costs, lack of business acumen (Sao

Lang 2005). The second literature review explored the emerging role in the USA of oncology nurse practitioners (numbers unspecified) as partner in collaborative private practice (Bush & Watters, 2001). This review was also unspecified in date and criteria but was said to include other aspects such as personal experience. The authors concluded that major obstacles were developing a supportive, collaborative relationship with oncology physicians in order to achieve shared care authority, limited/inconsistent prescriptive authority in different states, insurance reimbursement problems accompanied by lack of professional role recognition.

Within the international nursing organisation literature it is possible to identify that legislative change has had a direct impact on providing business opportunities for nurses.

Examples for nursing and midwifery include:

- In New Zealand new health and safety legislation, which required organizations to have health and hazard risk management, created the business opportunity for occupational nurses to become self employed and offer that service (GNA, 2005)(p11).
- Also in New Zealand, an act permitting midwives to care for women without the involvement of an obstetrician and or GP in 1990 has promoted the practice of independent midwifery (Fleming 1996). Under this legislation the birth may take place at home or in a hospital. Furthermore, as from 1995, women in New Zealand have been able to choose their Lead maternity care giver and many are choosing independent midwives (Stimpson 1996).
- In Germany, the introduction of the Long Term Health Insurance legislation in 1995, created the opportunity for nurses to become self employed in providing home nursing care, to be purchased directly by the insured person. (GNA, 2005)(p4). In the United States, legislative changes such as The Balanced Budget Act (1997) and more recently The Medicaid Advanced Practice Nurses and Physician Assistants Access Act (2005) have provided new opportunities for advanced practice nurses/independent nurse practitioners, to provide health care services and get direct reimbursement, independently of physicians. This has created the business opportunity but it is not clear the extent to which this has been taken up (The National Nurses in Business Association May 2005).

- In the Netherlands, the organisation of the insurance system coupled with a law regulating health care fees allow the government to control costs by specifying the rules of coverage and what will and will not be covered has protected the economic interests of the private midwifery practitioner (De Vries 2005). For persons insured with the health insurance funds, the health care insurer finances the costs of antenatal care and care during and shortly after the birth. The costs of an outpatient delivery (delivery room) in a hospital attended by a midwife and care by a gynaecologist are only reimbursed if there are medical indications. Until mid-2001 government protection and promotion of midwives practicing independently was also assisted by a *primaat* – coverage rules that required primacy of midwives for women insured with the health insurance funds. The Midwifery for Persons Insured with the Health Insurance Funds Decree stipulated that a GP would not be reimbursed for midwifery care provided by him or her if there was an active midwife under contract to the funds in the region¹⁰.

In developing countries private sector provision of healthcare has also been encouraged in recent years as part of wider health sector reform programmes, There have been changes in government policies in a number of African countries (eg Tanzania, Zimbabwe, Uganda, Zambia) during the 1990s that have opened up the possibility of officially sanctioned private practice for nurses. However, the specifics of autonomous nursing and midwifery activity in the private sector has tended to receive relatively little attention from policy makers and from researchers (MacDonagh, Murray & Ensor 2003). An exception is Indonesia, where great efforts were made during the 1990s to place “one midwife in every village”. Some 56,000 young midwives were trained and placed on 3-year contracts between 1991 and 1997 then encouraged to go into private practice to support themselves when that contract expired (Geefhuysen 1999), However sustainability has proved difficult in practice and in 2002 the government tacitly abandoned its goal of midwife

▪ ¹⁰ On 11 June 2001 the Royal Netherlands Association of Midwives (KNOV) and the National Association of General Practitioners (LHV) entered into a covenant containing agreements on mutual relationships and collaboration. Because of this, the primacy system could be allowed to lapse (Poorter 2005).

privatization by allowing unlimited contract renewals for many government-funded midwives (Suk Mei Tan 2005).

Private Nurses and/or Midwives Associations exist in a number of these countries and as international interest in public/private partnerships has increased some have received technical assistance from USAID and other donor organisations in the areas of marketing & the creation of income generation activities, management guidance, quality improvement packages, and the establishment of group purchasing plans for Family Planning commodities (Abt Associates inc. 2005; Mantz 1997; <http://www.psp-one.com/content/announcements/detail/3027/>). A variety of contracting and franchising arrangements are being tested, UNICEF, for example, facilitated the creation of a Private Midwives Association in the Bari Region of Somalia in 1997, and signed an agreement for the delivery of immunisation and other MCH services, including the provision of antenatal care through the association (UNICEF Somalia 1997). And in the Philippines the USAID 'Tango' projects have supported the development and evaluation of a 'social franchise' model for family planning and MCH services called the Well-Family Midwife Clinic (John Snow Inc 2005).

Few of the empirical studies conducted outside the UK have discussed outcomes for patients as a result of services from nurse entrepreneurs, those that do indicate variously that there can be obstacles to the provision of good quality care and that access to certain types of service can be increased. Obuobi's (1999) study of private sector activity in Greater Accra, Ghana for example, included focus group discussions with private midwives who worked in solo practice and operated maternity homes, averaging 12-15 deliveries per month. This group of midwives highlighted difficulties gaining cooperation from government service providers for referrals of their patients. IntraHealth International (2005)'s evaluation of The PRIME II Project seems to indicate the value of offering specific new skills training to the private sector in some circumstances. An audit of client tracking forms at 94 facilities over three months indicated the impact of training 79 private and NGO sector nurse-midwives and 22 clinical officers in post abortion care. (Complications from unsafe abortion account for more than a third of all maternal mortality in Kenya.) This audit indicated that as a result of the initiative 1,603 women with post-abortion complications were treated successfully with manual vacuum aspiration, 81% of the clients were counselled in Family Planning methods and 56% accepted a method,

and over half of the post abortion care patients received counselling for prevention of HIV/STIs.

Harris (2000) looked at why women choose to give birth at home and midwives work independently in Australia in a culture that does little to encourage these options. Mortality and morbidity rates in Australia and New Zealand, as well as in the Netherlands, England and the USA were compared in the light of different attitudes to homebirth and Harris concluded that homebirth is a safe option that should be supported by independent midwives in Australia. Pairman (1998) studied the nature of the relationship between midwife and woman and the understanding these parties have of this relationship. This small New Zealand study involved interviews with 6 midwives and 6 women maternity care users, exploring the choices women made in terms of provider and the outcome for those women that choose self-employed midwives.

Two more detailed social science studies were identified, focusing on maternity care provision. The yet to be published work by Rolfe et al. in Tanzania uses multiple case studies to test a series of hypotheses about independent maternity homes run by 'retired' midwives and concludes that in spite of their local in underserved rural and peri-urban areas, the bureaucratic, economic and cultural barriers to the expansion of this sector of provision have so far limited any significant contribution to improving coverage of skilled attendance at delivery. The authors flag up the importance of attention to local context in such analyses. De Vries's sociological study of maternity care in the Netherlands is a sophisticated exploration of the infrastructural and cultural context that sustains independent midwifery practice and with it a home birth rate of over 30% (De Vries 2004).

The international empirical evidence would indicate that that there were multiple factors involved in opportunities and choices to move into enterprise. It is not possible to be specific as to the extent offering choice to users of health care was a motivating factor for nurse and midwife entrepreneurs.

4.4. NMHV Entrepreneurship in the UK

In this part of the chapter we focus on the results of our literature reviews and e-scoping of UK NMHV entrepreneurial activity. We offer three 'analytical cuts' of this data. Firstly we map and analyse in some detail the types and extent of NMHV intra and entrepreneurial activity (the remainder of section 4.4). The second analysis

attempts to better understand the private/public configurations through the application of a provision/ financing/decision-making framework (section 4.5). Finally, in the third analysis we examine the ‘aspirational claims’ made in the documents concerning self-employed and business NMHV entrepreneurial activity, and consider whether and where the enhancement of patient choice fits within these claims (section 4.6).

There is no single organisational body or source of information on the extent of NMHVs behaving intrapreneurially or entrepreneurially in the UK. We have therefore focused on those NMHVs working within the healthcare system or connected to health care and not those who are professionally qualified but now working in different sectors¹¹. During the course of the study the discussion of entrepreneurial activities and behaviour by nurses has been increasingly visible in the public domain. Examples include:

- Platform presentations on nurse entrepreneurs and enterprise in conference programmes aimed at nurses in primary care
- Platform presentations on nurse entrepreneurs conferences aimed at managers and clinicians addressing long term conditions
- The DH(England) funded nurse entrepreneur education programme at the Oxford Said Business School, The Skoll Centre (DH England 2005)

4.4.1 The range of NMHV entrepreneurial activity in the UK

We have analysed the evidence of entrepreneurial behaviour by N,M, HV and suggest a typology that distinguishes between those who are employees— the intrapreneurs (see Chapter 2) — and those who are employers or self employed (the entrepreneurs). We have identified some distinct categories by activity within each of these and list these in full in Box 1. For each group we report on the extent of current

¹¹ ¹¹ It is beyond the scope of this review to consider the impact of the NMHV background and training on entrepreneurs whose activities are outside the health and social care field. Never the less there are notable examples such as Ann Gloag , a former Scottish nurse who achieved enormous international commercial success in the transport industry (current fortune estimated to be £385m Times Rich List 2006). Less well documented are her philanthropic activities in the provision of health care internationally (including the Mercy Ship floating hospital ships) and education for health professionals, particularly nurses in Scotland (Marie Curie 2001) and the endowment of a chair in nursing.

activity as reported in the documents reviewed and in the e-scope and expert seminars, summarise what is known about the contextual and individual - drivers (the 'push' and 'pull' factors including specific triggering events), the barriers to expansion of activity, and the questions raised for future investigation.

Box 1 A typology of NMHV entrepreneurial activity

1. The NMHV entrepreneurial employees (intrapreneurs)
 - a. NMHV in quasi-autonomous public health roles
 - b. NMHV in clinical specialist roles
2. Employers/self employed providers of services with an indirect relationship to healthcare
 - a. Nurse consultancies
 - b. Infrastructure and workforce providers
 - c. Inventors /manufacturers
3. Employers/self employed providers of direct healthcare services
 - a. Mainstream health services delivered through the NHS
 - b. NMHV services offered directly to clients
 - c. Other health related services provided by NMHV directly to a client
 - d. Accommodation with nursing and health related services provided by NMHV proprietors

4.4.2 The intrapreneurial NMHV employees

The boundaries between activity aimed at service improvement and introduction of innovation, professional leadership and behaviour that might be described as specifically 'intrapreneurial' is hard to define. Innovation and change is a constant feature in most health care organisations. Innovations have been described as occurring along a continuum ranging from incremental (i.e. related to service improvements, population change and patient empowerment issues) to revolutionary innovations (i.e. influenced by change in financing, techno/biotechnology (Asoh, Rivers, McCleary & Sarvela, 2005). Descriptions of NHS innovation involving nurses and midwives and small scale innovation evaluations are legion. They feature in every edition of the nursing press, in Department of Health information and guidance

documents aimed at nurses and in annual award competitions run and reported by journals such as the Nursing Times and the Health Service Journal. Against this background, it is possible to identify two groups of NMHVs who might more closely fit the description of employees behaving in entrepreneurial ways to the benefit of the users and the organisation i.e. as intrapreneurs. These are:

- NMHVs in quasi – autonomous public health roles
- NMHVs in clinical specialist roles

Nurses, midwives and health visitors in quasi – autonomous public health roles

Health visitors and those nurses educated in the public health tradition in the UK have an underlying role philosophy of identifying unmet health (in the broadest sense) needs in the population and seeking ways to address these. It is perhaps best encapsulated by the statements used to describe the principles of health visiting at an individual, group and population level as:

- The search for health needs
- The stimulation of awareness of health needs
- Influencing the policies affecting health
- Facilitation of health enhancing activities (Twinn and Cowley 1992)

Thus the roles of health visitors, nurses and midwives working in public health have tended to encourage autonomous and innovative behaviours. There have been more opportunities for intrapreneurial work than for other types of nurses, particularly with increasing emphasis on cross-agency working and networking with the voluntary sector and local authority sectors. We identified more than 260 published examples spanning a wide spectrum of activity in this area (some examples are given in Appendix 4 Table 1a) . At one end of this spectrum, the development of new services may only involve the re-organisation of the NMHVs time to provide their own services differently or more accessibly to a particular client group (e.g. Harrison and Berry 2006). However, at the other end of the spectrum, there are NMHV activities that are more overtly 'intrapreneurial'. These include:

- Those who work using the principles of community development or community engagement in helping communities identify their own health issues and working with them to address those e.g. Grant 2005. There are examples

where the nurses and health visitors not only work in these ways but actively draw in additional funding from outside the health service e.g. the health visitors leading the development of a tenants association that subsequently gained £1.2 million government urban renewal funds (Beacon Community Regeneration Partnership undated) , from charities e.g. an financial award from the Queens Nursing Institute to a health visitor led an community health project based in a community flat on a deprived estate (Daniel 1999).

- Those providing health care services in a manner which appears pioneering or 'risky' for the NHS. An example would be innovations to improve the access to post-coital oral contraception in school settings as instigated by school nurse Viv Crouch in response to the local reduction in teenage pregnancy strategy (Crouch 2002) . This resulted in local and national outcry as to acceptability and led to questions in the Houses of Parliament (Tonge 1999).

These kinds of activities predate the policy changes from the mid 1990s and have often been tied to improving access and addressing health inequalities (see for example Drennan 1988). Many have been short term projects limited either by the temporary nature of the funding or by reliance on a single innovative individual whose eventual departure leaves a gap that cannot be filled. The nature of the documentation of such projects often makes it difficult to discern to what extent a N,M or HV could be considered the prime agent in the activity, to what extent it was a multi-professional initiative, what were the outcomes and for how long the activity was sustained.

In the accounts of this activity the drivers tend to be described in terms of 'fulfilling one's job role' and 'addressing inequalities in health', often claiming legitimacy by citing from government policies on public health (DH 1999 Cm 4386) or World Health Organization statements such as Health 21 (WHO Regional Office for Europe 1999) . In the literature that we have found, key obstacles to innovation and intrapreneurial activity here are reported to be limited finances affecting sustainability, difficulties surrounding decision making and finding support between multiple agencies and the controversy that some initiatives generate. We discuss this further below after discussing the second group of more entrepreneurial employee NMHV.

Nurses, health visitors and midwives in clinical specialist roles

NMHV working as clinical specialists are a second group of employees that exhibits more entrepreneurial behaviours. Clinical nurse specialists are a group who focus on one condition, health problem or specific population group and are recognised as expert in that field, often sought as advisors to others and involved in service developments and innovations. However, it is difficult to separate instances of service improvement, direct substitution of single medical tasks from instances where NMHV provide a full service more entrepreneurially, in which care is assessed, managed and evaluated by the nurse in partnership but without direct medical input. There is an extensive literature of UK 'nurse-led' specialist services for example the DH (England) funded study on exploring new roles in nursing practice (ENRiP) in the acute sector (Read et al 2001) estimated about 3,000 clinical nurse specialist roles involved nurse-led activity nationwide. The ENRiP case study work demonstrated great variety in support and obstacles experienced by those in new clinical nurse specialist roles (Read et al 2001).

'Agency' and 'risk taking' are often said to be defining characteristics of entrepreneurial activity. We have illustrated some of the specialist NMHV roles within public sector organisations that could be said to involve one or other or both of these characteristics in Appendix 4.3 table 1b. Examples include; a nurse-led service to manage problems of intractable constipation in children in Oxfordshire (Muir & Burnett, 1999), a nurse-led heart failure and cardiac rehabilitation clinic at Basildon Hospital, Essex (Ayers, 2005) and nurse-led cystoscopy and follow-up telephone counselling service for patients with prostate and bladder cancer at Grampian NHS Trust in Scotland (Hoban, 2006), community mental health nurses providing advice for people with anxiety, depression or life difficulties in southern England (Kendrick, Simons et al. 2005), consultant midwives working to reduce caesarean section rates by developing counselling services for women who request caesareans without medical indications (Dunkley-Bent 2004). Many of these accounts make it clear that the drivers included the desire to create patient focused care, to maximise the use of their expertise, and to improve the types of service offered by the NHS. Supporting environmental factors which were exploited included medical consultant support and government policy priorities such as reduction in junior doctor hours, and waiting time targets.

Intrapreneurial NMHV and health organisations

Innovative and challenging ideas are not always welcome in large bureaucracies, and a small literature describes the problems encountered by members of the NHS workforce in trying to gain organisational permission to behave in ways that are different and creative (see for example McMurray and Cheater 2004)

Several contributors to the expert seminars also cited these difficulties as the impetus for their own departure into independent practice. Seminar participants wanted more autonomy over their work and reported the frustrations of what they perceived as inhibiting practices. For example one participant said:

'If I reflect that when I qualified as a health visitor in '73, we were told, 'there's your caseload, get on with it. Do with it what you wish'. Nobody checked up on us, so I did with it what I wished. And by the time it came to be constraining, I'd moved into education, and I was teaching my students to do with it what they wished! We were taught to be autonomous and to have a look and to make decisions. And I think, for me, that actually when the NHS started to shut down all that, I found that really hard. That wasn't the way I functioned'.

However, there are also examples from the literature where local NHS organisational support has been very explicit in creating posts for 'leaders' and 'innovators' with job descriptions that embody and enable these types of activity. These are usually created in recognition that conventional approaches to care and service delivery have failed some of the most vulnerable groups e.g:

- Outreach sexual health and contraception nurses with a remit to provide their services in ways and places acceptable to particular client groups such as men who have sex with men, teenagers, sex workers (Knox, 2004)
- Consultant midwives within NHS Trusts with responsibility for public health running community clinics focusing on domestic violence, the sequelae of rape and sexual assault, traumatic childbirth and mental ill health (Dunkley-Bent, 2004).
- 'Sure Start midwives' working with poor communities, and with specific client groups that are often difficult for maternity services to reach such as pregnant women who are substance abusers (Hutchings & Henty 2002, Khazaezadeh 2005, Wilyman-Bugter 2003).

- Community development health visitors (for example Dalziel 2000, Swann and Brocklehurst 2004,)
- Specialist in complementary therapies using massage, reflexology and aromatherapy within the hospital setting (for example Lyall 2005)
- Outreach mental health nurses working with young people with sexually harmful behaviours (National Institute for Mental Health in England 2005 <http://kc.nimhe.org.uk/index.cfm?fuseaction=Item.viewResource&intItemID=81232>)

It is not clear which factors make it easier for individuals and organisations to support such intrapreneurial activity or whether these are different from the known factors that support and sustain innovation in the NHS. It is possible to hypothesise that certain public sector environments are more nurturing of intrapreneurial activity where there is:

- Greater availability of local level funds such as the single regeneration budgets (Department of Communities and Local Government 2006)
- Public sector service policies, such as public health policy (DH 1999) that explicitly describes NMHVs acting in this way
- Central government funding for cross agency initiatives such as Health Action Zones (DH 1997) ,Sure Start (DH 1999), Crime and Disorder Partnerships (Crime and Disorder Act 1998)

Research Questions

To what extent is any intrapreneurial activity in the NHS the result of one person's activity, drive, motivation?

What are the key features of an NHS organisation that supports intrapreneurial activity by N,M, HV ?

What factors external to an NHS organisation are likely to support or inhibit intrapreneurial activity by NMHV ?

Is there any link between the types of education, background and/or the level of seniority that supports intrapreneurial behaviour in NMHV ?

To what extent do the relationship with doctors (and which types of relationships with which types of doctors) support or inhibit NMHV intrapreneurial behaviour ?

Do NMHV roles that have clearly defined focus and boundaries encourage intrapreneurial activity on behalf of their client groups?

Before leaving this section on intrapreneurial behaviour, we suggest that it is worthy of note that intrapreneurs often cross boundaries of working within the health care system and working along side but outside. This appears to be a characteristic of some NMHVs who have been working on innovative/cutting edge/risky services within the NHS, have actively publicised their work, often their names are nationally associated with this activity and have then left the NHS (sometimes to the associated public sector of health professionals education) but continued the activity or an aspect of it outside the NHS. Two examples:

- Professor Elizabeth Aninowu, who established the first nurse-led sickle cell counselling service in the UK in the Brent haematology service, raised public awareness of the deficiencies in the NHS response to black and ethnic minority health issues, promoting improved counselling and care services (Aninowu 2005). She was a founding member of what became the UK Sickle Cell Society and has continued since the 1990s to be actively engaged in this area from the higher education sector (see for example Anionwu and Atkin 2001).
- Ellie Lindsay, who as a district nurse established 'leg clubs' for older people to prevent ulcer reoccurrence and provide social interaction opportunities , then left the NHS for higher education and also set up a charity (the Lindsay Leg Club Foundation) which promotes the 'leg club 'model in the UK and Australia (see <http://www.legclub.org/index.shtml> , and Pollard 2004)

These examples illustrate the unpredictable career trajectories of intreprenurial nurses even when their focus is based on responsiveness to patient need.

4.4.3 The NMHV Entrepreneurs in the UK

As indicated earlier there is no single register, organisation or source of information revealing the types or extent of NMHV entrepreneurs as owners/employers/partners of enterprises in the UK. While the Royal College of Nursing has 201 registered members of the *Nurse Entrepreneur Forum* (Smith 2006 personal communication) this is only for members of the RCN and thus gives only an indication of potential

numbers¹². This membership is unlikely to include many midwives. At the time of our scoping there were 115 independent midwives registered with the Independent Midwives Association, and an indeterminate number of others who practice independently but who are not members (Eleanor May-Johnson personal email communication May 18 2006).

In order to understand the extent and character of NMHV's activities in business we have constructed a categorisation, from the examples we have found, based on the types of products/services (see Box 2). We have done this as much of the literature provides little detail to categorise the examples in other ways e.g. type of business trading (sole, partnership, limited company, co-operative) or commercial versus social entrepreneurship (see also Chapter 2). The lack of detail in the accounts does not always allow us to distinguish accurately the extent to which these services are bought or commissioned by the public or private sector or by individual patients/clients (see section 4.4.).

Box 2. A typology of NMHV entrepreneurial activity

1. The NMHV entrepreneurial employees (intrapreneurs)
2. Employers/self employed providers of services with an indirect relationship to healthcare
 - a. Nurse consultancies
 - b. Infrastructure and workforce providers
 - c. Inventors /manufacturers
3. Employers/self employed providers of direct healthcare services
 - a. Mainstream health services delivered through the NHS
 - b. NMHV services offered directly to clients
 - c. Other health related services provided by NMHV directly to a client
 - d. Accommodation with nursing and health related services provided by NMHV proprietors

¹² This RCN forum produced the first UK guidance for nurse entrepreneurs in 1994 and are now on to their third edition (RCN 2003). The guidance provides detailed information on legal, insurance and financial issues as well as giving case examples.

Within the employer/self-employed category, we distinguish between providers of services with an indirect relationship to healthcare and providers of direct healthcare services. This does not mean that individuals necessarily only operate within one category. It is noticeable that many of those operating as sole traders (self-employed) providing direct clinical care also offer nurse consultancy services. We detail the extent and available evidence on the context, drivers and barriers and outcomes for each group. We indicate in each section the questions raised from the evidence and summarize this at the end.

4.4.4. Providers of services with an indirect relationship to healthcare

A. The NMHV consultancies

These NMHVs use their expertise, knowledge and experience to provide consultancy to a wide range of public and private sector organizations. The types of expertise they offer in consultancy are

- Clinical leadership and advice on health care delivery
- Service commissioning or clinical practice review or audit
- Service or clinical practice project planning and implementation
- Training programmes/workshops
- Expert witness opinion in legal cases
- Risk management assessment and planning
- Occupational health and safety advice
- Individual coaching , motivational and personal development ,career advice

Table 2a (Appendix 4) provides a sample of these consultancies from published information. In total we have identified 40 nurses, 4 of whom were men. Many of these individuals reported they were senior managers or clinical nurse specialists with many years experience in the NHS. Others are nursing or midwifery academics. Among some of the reported drivers behind the move into individual consultancies were NHS management and education reforms and the downsizing of NHS organisations and associated schools of nursing. Other factors were the desire to be in control of one's own activities, to gain recognition for their work and to have more flexibility in working times. We found three examples of black and minority ethnic nurses offering NMHV consultancies , only one of these was a published account (Thompson 2005). Given the literature on the entrepreneurial activities of black and minority groups in the UK and in particular, women from Caribbean and Asian backgrounds (see Chapter 2). While this may reflect the nature of the literature

it does raise questions about the extent of entrepreneurial activity in NMHV from minority ethnic backgrounds.

The individuals' accounts report benefits such as personal and professional satisfaction, time flexibility and being one's own boss rather than being dictated to by an organisation. Reported problems included the slow start in getting the enterprise off the ground, concerns about peaks and troughs in the work and uncertainty about income levels. These factors mirror many of the drivers and barriers seen in the women's entrepreneur literature and previously identified in Chapter 2. It should be noted that some of this type of work is undertaken by many who are also working for the NHS at the same time e.g. acting as expert witness, media and television advisors. Indeed some of these nurses in consultancy reported working for the NHS as temporary staff when they did not have enough consultancy work.

Research Questions:

What is the age profile and years of health care experience of NMHV moving into enterprise ?

To what extent does the NHS lose NMHV with significant clinical expertise to enterprise from areas experiencing organisational turbulence?

To what extent do clinically and managerially experienced NMHV develop portfolios of different types of work and income streams?

Is the career trajectory of male NMHV entrepreneurs the same or different to female NMHV

To what extent are NMHV from black and minority ethnic groups represented in the entrepreneurial categories and are their career and entrepreneurial trajectories similar to NMHV entrepreneurs from majority ethnicities?

An additional category of nurse consultancy was reported in the expert seminars, one in which clinical nurse specialist acted as a private care commissioner on behalf of individual patients. This nurse worked with 14 children with acquired brain injury, and her role was to use her technical knowledge to commission care for them from other experts, not to provide the care herself.

B The Infrastructure and workforce providers

We identified 4 nurse entrepreneurs running businesses which provided infrastructure services or staff to health care services (see Table 2b Appendix 4). Though there are likely to be further examples, the cases we found have been

particularly visible in the media and are repeatedly cited as examples of nurses working in business. This media focus has concerned:

- Their business success e.g. Ann Rushworth founded the ScotNursing , agency for temporary nursing staff in 1996 and now has an annual turnover of £10 million (www.scotnursing.com)
- Successfully identifying a market gap e.g. Kate Bleasdale founded MediCentres, the first private GP walk-in services in railway stations, an idea later picked up in the NHS Plan (DH 1999).
- Successful examples of private-public partnership or third sector enterprise promulgated in health policy for England e.g. Sarah Chilvers in partnership with Rory McCrea (a GP) established Chilvers McCrea Health Care Vision to provide corporate management services to general practice and more latterly to provide the entire service under APMS contracts (Gould 2000, Chatterjee 2005, www.chilversmcrea.co.uk) .
- Controversy e.g. Kate Bleasdale won an out of court settlement of reportedly £2.2 million for alleged sex discrimination and unfair dismissal from the nurse recruiter recruitment company MATCH that she founded and led as chief executive (Vasagar 2002)

The scoping did not reveal accounts of failure or nascent NMHV entrepreneurs in this field. It did however, reveal involvement in the wider business world not discussed in any other part of the scoping e.g. companies being floated on the stock market, mergers with other companies, takeover bids and management buy outs. Much of the literature about these entrepreneurial nurses comes from news reports and therefore there is little information about motivation, or drivers and barriers more generally. Market opportunities are presented in different ways e.g.:

- Offering the public a choice in provision e.g. private GP walk-in centres in railway stations
- Offering competitive services on efficiency and effectiveness e.g. corporate infrastructure services to general practice, provision of temporary staff

Kate Bleasdale left the NHS and set up her first company in her twenties and within 4 years of qualifying as a nurse (Wallis 2003), an unusual pattern compared to the literature on women entrepreneurs. Sarah Chilvers and Kate Bleasdale have

reportedly been involved in more than one enterprise, suggesting the characteristics of 'serial entrepreneurs' are to be found amongst some of this group. Rushforth, a former midwife, is reported to have started the ScotNursing agency from her spare room partly because it was impossible for her to find work which would fit in with her family of three children under 4 yrs, and partly out of a desire to run her own business (Darroch 2005). It should be noted that there are also two examples of the companies these nurses founded providing direct patient care – although they themselves did not. This illustrates the overlapping nature of some of these categories.

It is not clear whether these individuals are still registered to practice as NMHV in the UK. In some instances the words 'former nurse' are used to describe them, however their nursing qualifications are often given with their name.

Research Questions

Are the drivers and barriers different for NMHV moving into enterprise than they are for other women entrepreneurs in the UK ?

Are the career trajectories of NMHV involved in these types of enterprise similar or dissimilar to those of UK women or men entrepreneurs or to other types of NMHV intra/entrepreneurs?

Are the failure rates of nascent NMHV entrepreneurs comparable to others setting up in business in the UK?

To what extent does the use of NMHV qualifications aid or detract from entrepreneurial activities?

To what extent do NMHV entrepreneurs create choice for patients or respond to known gaps in service provision ?

C Inventors /manufacturers

Inventors and manufacturers were the final group of NMHV we identified as behaving entrepreneurially in indirect care. We identified 6 examples (listed in table 2c Appendix 4) ranging from medical devices for use in patient care e.g. ear wax softener applicator, to health promotion artefacts e.g. a board game to raise sexual health issues with young people with learning difficulties and for health professionals e.g. miniature laminated memory aides. The reported drivers came directly from the experience of providing services and a desire to improve patient care. Some of the accounts of these inventors and manufacturers are journalistic and as such the financial start up, the outcomes and aspects of intellectual property rights issues are

not always clearly described. One of the inventors was also part of a family farming business (Porokhynya 2005).

We have one further example where a health visitor working in higher education , identified the need for a chair that allowed better positioning for breastfeeding in comfort. She took her idea to a design student, who developed the idea as doctoral work and subsequently took her work to an independent manufacturer. The chair is now in production and commercially available. The health visitor entrepreneurial activity from a practice based need was instrumental but is not is not necessarily now visible (Jones , Rogers and Kendall 2006)

Research Questions

To what extent do entrepreneurial NMHV have family or previous experience of the business world ?

To what extent does the NHS encourage and support inventions by NMHV and deal with issues such as intellectual property rights ?

To what extent are NMHV providing the creative ideas, identifying the market gaps, initiating entrepreneurial ways of addressing them but leaving them to others to develop and profit from?

We turn now to those NMHV providing direct healthcare services either as self-employed individuals or as employers.

4.4.5. Providers of direct health care services

These can be categorized into 4 groups:

- a. Mainstream NHS health services through direct contract with the NHS
- b. NMHV services provided directly to clients
- c. Other health services (e.g complementary therapy and cosmetic services) by NMHV provided directly to clients
- d. Accommodation with nursing and health related services provided by NMHV proprietors

Entrepreneurs in this group may be funded in a number of ways (see section 4.4.5) . Here we describe the scope of this category of activity, with illustrative examples from each subcategory.

A . NMHV providers of 'mainstream' NHS health services

This is a diverse group in trading status and contractual mechanisms with the NHS. The diversity has increased during the life of this project and is set to increase as the government has announced support for the increased presence of 'third sector providers' (DH 2006) in health care outside of hospitals in England (see Chapter 3)

The groups we have identified are:

- Nurse as partners in general practice businesses with a national (general medical services, GMS) or local (personal medical services, PMS) contracts with the NHS
- Nurses as sole traders and partnerships in providing personal medical services (PMS) under the Primary Care Act 1996 regulations i.e. comparable to those specific in the general medical services contract, contracted with the local Primary Care Organisation (PCO).
- Nurses providing personal medical services under alternative provider medical service (APMS) contracts i.e. comparable to those specific in the general medical services contract with general practices, contracted with the local PCO
- Nurses as directors of not for profit companies providing community health services (not personal medical services) under APMS and specialist provider medical services (SPMS) regulations , contracted with the local PCO
- Independent midwifery practices sub contracted from an acute Health Care Trust as in the Albany / King's College Hospital Trust arrangement (see section 4.4.1)

Written examples are given in Appendix 4 Table 3a and an explanation of the various primary care contracting routes are outlined in Appendix 4.1)

Nurse partners in general practice and nurse led personal medical services

Partnership for nurses in general practice businesses became a legal option for contracting within the NHS with the NHS (Primary Care) Act 1997 which allowed a PCT to contract with the practice rather than the national contract with individual general practitioners. The first nurse partner with a GP in a general practice business was announced as part of the first wave of 94 new PMS contract pilots in

1998. In 2006 there is reported to be a network of up to 100 nurse partners and prospective nurse partners (Pearce 2006). The increase is reported to be promoted by the legislative changes to primary care contracting in 2004 (Crumbie 2006) and is illustrated by the production of guidance on how to be a nurse partner issued by a DH funded organisation National Primary and Care Trust Development Programme (NaCTPaCT 2005) and professional nursing organisations such as the Queens Nursing Institute (QNI 2005). There are three different levels of nurse partnership with different levels of financial investment in and return from the practice. As pointed out in the NaCTPaCT Briefing paper, partnership in a general practice is not a risky financial business, as illustrated by recent media accounts of GP incomes in excess of £100,000 (see for example Hawkes and Charter 2006) . The contract with the NHS guarantees income without risk of financial loss (NaCTPaCT 2005). While this is a growing number, it is still small in comparison to the 10,683 general practices (UK RCGP 2005) and practice nurse workforce (see Chapter 2) . We found written accounts of 5 nurse partners with GPs, 3 established in the first wave of PMS pilots and 2 since (see Appendix 4 table 3a). All of the accounts describe a long history of working in that general practice and developing a role and services which implies there are certain contextual and relational pre-requisites for NMHV being invited to become business partners. All accounts place emphasis on the positive contribution to holistic patient care, a nurse led approach or culture. The only barrier reported by one nurse partner was surprise that the Royal College of Nursing does not indemnify a business partnership (Crumbie 2006). There are no accounts of the impact, sustainability or effects over time. The advent of nurse partners in general practice indicates nurses becoming business women/men rather than necessarily entrepreneurial risk takers with innovatory ideas for patient care or choice.

Of the 94 first wave personal medical services pilots announced in 1998, 2 were led by independent nurses gaining contracts with PCTs and employed salaried general practitioners. A further 7 were involved in nurse-provided PMS pilots, although it was usually the PCT that held the contract . These first wave of nurses were described repeatedly in the media in terms such as '*pioneers*', '*ground breaking*', '*in the vanguard*'. All but one of these nurses were female. Accounts were given by the nurses themselves, journalists, by an academic reporting on focus groups held with all of these nurses twelve months after starting (Lewis 2001) and by one evaluation of 28 patients' perceptions in one of these practices (Chapple 2000). Drivers of the entrepreneurial act were described in terms of the opportunity the legislation gave the individuals and nurses as a profession. Some of the drivers were described in terms

of opportunities to address the health care needs of vulnerable patients and improve health care in deprived areas. Support was described as coming from other nurses attempting to get nurse led contracts and from the active involvement of senior civil servants and leading figures in the nursing world. The barriers were described as the isolation, lack of a safety net, negative attitudes from some doctors, some managers and some nurses. For example, one nurse, who attended an expert seminar, described the isolation they felt because they were '*treading ground no one had trodden before*' and stating that '*every GP wanted me dead, but nurses wanted me more!*'. Another barrier was the lack of parity between doctors and nurses in health care administration e.g. signing death and sickness certificates and prescribing powers. It was also noted that the Act did not allow the health authorities to allocate premises improvement grants to nurses as they did to doctors. One of these nurses reported patients' concerns about whether this type of practice meant there was a two tier system of healthcare (Chapple 2000) while another cited the increased level of patient registration as evidence of success (Baraniak 2001). Interestingly one of the nurse-led PMS pilots established an innovative governing body modelled on that of the school board of governors involving patients and city councillors to help direct the work of the nurse-led PMS (Chapple 2000) There are no published patient or practice outcomes reported in these accounts, which focus rather on the process of setting up. Informants from the expert seminars suggested that there was practice level data within PCOs showing improvements in public health and chronic disease management indicators in comparison to prior population figures (see Chapter 7). However, it is difficult to say how far this is an example of new workers annexing an old model of care or a radical change in primary care provision led by entrepreneurial NMHV's.

There is no published information to show how many of these first nurses remain leading personal medical services. One left after two years and is quoted as questioning the premise that the most vulnerable and needy in the community were best served by nurse-led PMS when the reality was that the best services relied on a partnership between GP and nurses (Moore 2002).

The government established PMS as an permanent alternative form of contracting to the GMS contract and by 2004 37% of all general practitioners (n=11,547) were using this form of contracting rather than the GMS contract (RCGP 2005) . There is no published information as to the extent to which nurses have continued to take the option of nurse-led PMS since the first wave.

We have found only one account documented subsequent to the first wave PMS pilots that describes a partnership between the practice manager and the practice nurse (also a health visitor) to gain a PMS contract with the PCO , taking over their employer's practice on his retirement. Interestingly , this is one of the few accounts that describes the finance involved, which was the raising of £250,000 loan from a bank to buy a practice from a GP, and also reports the nurse describing herself as 'a bit of an 'entrepreneur and a risk taker' (Houghton 2002) . It is noteworthy that a nurse setting up in practice is perceived as entrepreneurial , while a doctor setting up a practice would be seen only as a business person. This account notes that one of the barriers remains as the difference in prescribing authority between doctors and nurses (although the 2006 legislative changes on non medical prescribing alters this in England) and the difficulties in attracting GPs to work in salaried positions with a non GP led practice. Perhaps this indicates a more widespread resistance to nurses taking the employer role or holding these forms of contracts.

Alternative provider medical service (APMS) and specialist provider medical services (SPMS) contracts with the NHS

The negotiation of the new GMS contract in 2004 was instrumental in the government creating a new category of primary care contract, known as APMS (alternative provider medical service). This opened the way for a range of public, private, not for profit organisations to tender to the PCT to provide specific personal medical services or parts of them e.g. out of hours services (Hutton 2004 , Maynard 2004,). During the lifetime of this project, there has been a third type of contract developed for a wider range of primary care services outside of general practice and that is the SPMS (specialist provider medical services DH 2005a).

In July 2005 the Department of Health announced a national procurement pilot to demonstrate how different routes of contracting with different types of providers could address problems in areas where it was hard to recruit GPs (NHS Procurement and Supply Agency 2005) examine. Increasingly over the last few months guidance has been issued on the tendering process and the variety of organisations that could be third sector providers for care outside of hospital (DH 2006b). The development of this new form of third sector provider is not without controversy (see for example BMA 2006 , ,Harding 2006). The types of organisations that have been tendering include existing GP partnerships (Aire 2006), small and large commercial (Snow 2006, Editorial 2006a) and not for profit (and mutuals) organisations (Harding 2006, Lewis et al 2006).

We have identified one company which has a nurse as one of the directors, gaining APMS contracts from PCTs to provide personal medical services (Chatterjee 2005, O'Dowd 2006). In addition we have identified a nurse partnership, which successfully tendered for an APMS contract using finance from a social enterprise company (Wilds 2005). One nurse and therapist manager-led bid to provide community nursing and therapy services as a stand alone social enterprise under a SPMS contract has been successful (Pritchard 2005, Edward 2005, Carvel 2006, Nolan 2006,). These enterprises are very recent and, in the positive and multiple media reporting, it is difficult to understand about the triggers, processes, impact or sustainability. It is noteworthy however, that other nurse led partnerships bids for APMS contracts (Editorial 2006b) have not been successful against a larger company UnitedHealthCare.

Midwifery practice contracting

Midwifery services in the UK currently 'belong' administratively in the acute rather than the primary care sector in financing and administrative terms. The Albany Practice contract with King's College Hospital Acute Trust in London is currently the only example of an independent midwifery practice with an NHS sub-contract to provide services to a specific population. Based in South East London this self-managed, self-employed group of midwives has offered continuity of care with a known midwife since 1997 with the aim of targeting certain groups of local women and improve equity of access in a deprived area of London. The group was previously run as a pilot funded by the NHS Executive which helped secure the subsequent contract with the hospital trust (Allen et al 1997). An evaluation of this midwifery practice showed high rates of breast feeding achieved in a population that otherwise might be expected to have very low take up of breastfeeding as well as high rates of home birth (Sandall et al 2001). The Independent Midwives' Association has submitted a proposal for a 'NHS Community Midwifery Model' to the Department of Health in which a set fee per woman would be paid by the NHS to independent midwives who would continue to enjoy 'different ways of working' (MIDIRS 2004). The intended model would build in full access to NHS facilities and so resolve for independent midwives the difficulties that have been experienced of obtaining NHS honorary contracts and providing vicarious liability cover.

The extent to which '*third sector providers*' or '*outsourcing*' becomes established in the NHS and represents a more significant shift in how primary care services are

provided compared to the growth in entrepreneurial roles of NMHV's remains to be seen.

Research Questions

What types of local and national level support, by which types of stakeholders, enable NMHV to compete for contracts for mainstream NHS services?

Are multi-disciplinary tenders for APMS and SPMS contracts likely to be more successful than N,M, HV only tenders ?

Are the tenders offered by nurse led organisations for APMS and SPMS contracts different in any respect to those offered by other groups ?

B. NMHV services provided directly to the client

The second category of NMHV providing direct patient care we identified were those whose N,M, HV services were provided directly to the patient/client and paid for by the patient (also see section 4.4.1). Our scoping identified 11 nurse examples, 5 of these from the grey literature (see Appendix 4 Table 3b Appendix). These consultation and care services concerned continence, stoma care, rheumatology, ear care, maternity care and general health assessment. This group overlapped with the N, M HV consultancies in section 6.3.1. We also identified one example where the service (women's health screening) was bought by companies who offered it to their employees.

A reported driver in one instance was early retirement from the NHS while two others described the opportunity to use their clinical expertise more flexibly in a way that gave them professional satisfaction. Reported barriers included the daunting prospect of being self employed, the erratic nature of referrals and clients and the costs of personal indemnity insurance.

'Private' or 'independent' midwifery practice, as it is usually termed, has a very long history in the UK, and prior to the 1936 Midwives Act which brought in a salaried midwifery system it was the norm (Hunter 1998). After the creation of the NHS in 1948 there was a steady decline in independent midwifery practice but it re-emerged again in the 1970s with a strong ideological commitment to the pursuit of less medicalized models of care than those encountered in NHS services. Numbers of independent midwives have remained small (currently a little over a hundred) and are mainly confined to the urban areas , but they have remained a vocal advocacy

presence for 'real' midwifery - for physiological childbirth and for models of 'woman-centred care' that attempt to enact power-sharing and empowerment of clients. The use of the term 'independent' rather than 'private' or 'entrepreneurial' in the literature about this group is not accidental. As Hunter (1998) puts it 'it is the very independence of independent midwives that is so important. They do not need to convince the sceptics, negotiate with the managers or challenge the prejudices of co-professionals – they just go ahead and practice'. Drivers for practising independently include providing choice to women of where and how women give birth, developing meaningful relationships with women, greater autonomy over one's work, achievement of greater work/life balance, frustrations with practising midwifery in the NHS and disagreement with specific practices such as continuous electronic monitoring in labour (Jackson,1998;Stephens,2005). Independent midwives in the UK have faced great barriers obtaining professional indemnity insurance since costs rose and the Royal College of Midwives withdrew cover for this activity and they often have difficulty negotiating honorary NHS contracts from Health Authorities ((Dimond 2004;Kacary 2005). Other reported barriers include problems with home-hospital interfaces and uncertainty about generating clients (Howes 2005; Coyle (1999).

Research Questions

To what extent do NMHV services directly paid for by the client offer something that is not available or not provided in an acceptable manner in the NHS ?

C. Other health related services provided by NMHV directly to a client

This category includes complementary and beauty therapies that are not usually commissioned by the NHS (although there is a great deal of variety in relation to complementary therapies).

There is no up to date literature detailing the extent of NMHVs providing complementary therapy services, paid for directly by clients outside the NHS. Andrews surveyed nearly 2000 complementary therapists across the UK and of the 426 who replied 63 were also registered nurses and /or midwives (Andrews 2003). The majority were female, practised as sole traders and for 57% their complementary therapy work was the sole source of income. The therapies they practised included homeopathy, reflexology, acupuncture, massage, reiki, hypnotherapy, and dowsing. While some reported negative experiences in the NHS as drivers of their move out,

others described the positive pull of wishing to work in the complementary therapy field or wanting more flexibility in their working lives for domestic responsibilities. Negative aspects of self employment were reported to be similar to those described in the enterprise literature (see Chapter 2) including unpredictability of income, lack of financial security, isolation. Seventy per cent reported that they would prefer to practise as employees of the NHS.

We identified no further published accounts of NMHV as complementary therapists although a number of complimentary therapy web sites were identified that referred to therapists as former nurses, health visitors or midwives. In these we also identified a wider variety in how these former NMHV were operating. We found websites for groups of therapists, websites for therapy centres in which the former N,M, HV was renting consulting rooms to other therapists, a website that detailed former nurses and health visitors establishing UK branches of the Massage in Schools Association, commercial status unspecified, providing instructors to schools and early years environments, and one website on which the former NMHV now complementary therapist reported setting up a charity to fund the provision of a specific complementary therapy to children (www.abreathforlife.org).

Another group of nurses, in the cosmetic procedures or beauty therapy field, were identified selling their services directly to the public. A news item reported that over 300 belonged to the RCN 'aesthetic nurse forum' (Strachan-Bennett 2005). The procedures provided included laser treatments, injecting botulism and collagen fillers. Recent DH (England) guidance has tightened up the regulation of providers of cosmetic procedures through the Health Care Commission. We were unable to identify further literature on this group of nurses.

D Accommodation with nursing and other health related services provided by nurse proprietors

In this category we identified nurse proprietors of care homes although we were not able to identify the extent or the involvement in particular types of care homes.

Andrews and Kendall (1999) identified in a survey and interview study of 100 private residential home owners in Devon, 30 (28%) were former registered nurses. It is difficult to know whether this is generalisable beyond Devon. Andrews and Kendall (1999) reported that the former nurse proprietors most commonly started in this business to gain greater control of their own career and to own a business. No

negative push factors from the NHS were reported. They speculated that any money orientated motivation was withheld from the researchers. They noted that the former nurse proprietors had little business management training, which became evident with the adverse market environment of the mid nineties, which made small residential home ownership more financially pressured and insecure.

We found only one other example of a nurse proprietor of a care home for people with learning disabilities (Taylor , 2005). The decrease in the number of independent care homes as a result of new regulations and new market economies (Netten et al 2005) might suggest that there are likely to be fewer nurse proprietors than in previous decades.

In these preceding sections we have explored the diversity of NMHV entrepreneurial activity in the UK. We have highlighted the NMHV contributions both in the fields of indirect healthcare-related activity and in direct healthcare provision. Through the examples of the latter, the variety and importance of financing arrangements becomes apparent. In the next section, therefore, we offer slightly different 'analytical cut' of that data, draw for this upon a model from the health economics literature to help us focus in on the ways in which the intra- and entre-preneurial activity devoted to the direct provision of health care are currently configured across the 'private' and 'public' 'divide'.

4.5 Public and private configurations of health care and the NMHV entrepreneurial activity in the UK to date.

This section presents a preliminary analysis of the documents specifically concerned with NMHV entrepreneurial activity in provision of *direct* healthcare care, using a theoretical framework that moves beyond a simple discrimination between 'public' and 'private' healthcare to separate out the dimensions of provision, financing and decision-making. This in turn assists in identifying the relationship between specific configurations and a 'patient choice' agenda.

Classification of public and private healthcare activity (Burchardt et al 1999)

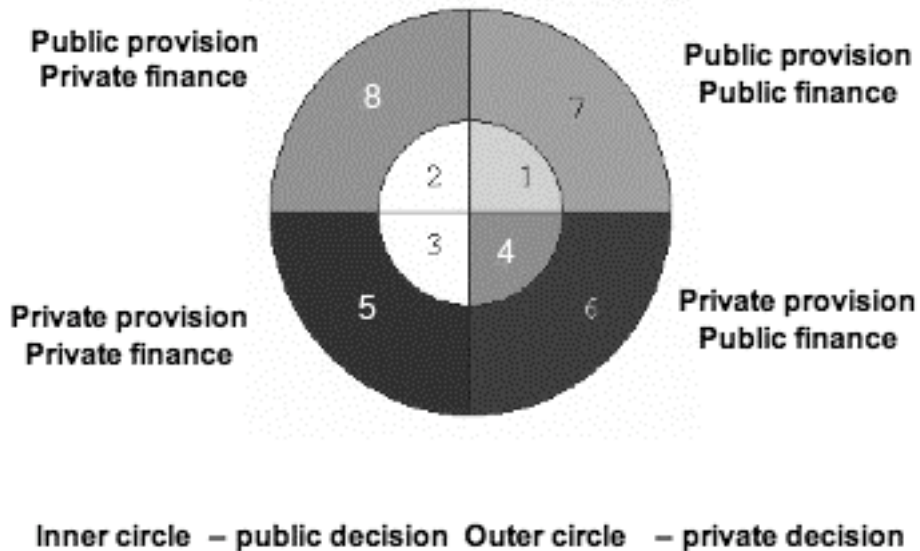


Figure 4.1 Classification of entrepreneurial activity in direct health care provision by decision-making, financing and provision.

In this ‘ideal type’ model constructed by Burchardt et al (1999) the ‘supply side’ of healthcare is divided into ‘public’ (government) and ‘private’ (non-government) provision, and the demand side is split into two parts, ‘decision-making’ and ‘finance’. Finance refers to the source of the resources, for example, state or local authority budgets, or out of pocket payments. Decision-making, depicted in the segments in the inner circle in the figure (segments 1-4): refers to whether the decision on what provider/ service/good to use taken by a public body, or by agents acting on behalf of consumers, or (as in segments 5-8) this choice is made by the consumer or ‘patient’ individually (Keen et al 2001).

So where does current N,M & HV entrepreneurial activity in the area of service delivery sit with regards to the possible public & private provision, financing, and decision-making combinations? We examined the documents that related to NMHV entrepreneurial activity and the selected examples about intrapreneurial activity around the direct provision of health care services and where they fitted within the Burchardt et al. classification scheme. The findings are given in Table 4.1

Finance / decision/provision combination	Total
Public decision	
Segment 1 (public provision/public finance/public decision)	36
Segment 4 (private provision/public finance/public decision)	31
Private decision	
Segment 5 (private provision/private finance/private decision)	24
Segment 7 (public provision/public finance/private decision)	1
Insufficient information	34
Total	127

Table 4.1: Finance / decision making / provision classification of NMHV direct healthcare activity in the UK to date

This allocation of information from a range of types of documents about entrepreneurial activity to segments is inevitably a somewhat crude exercise. One cannot necessarily assume that the documentation proportionately reflects the activity ‘out there’ and there was insufficient information in many of the documents to be able to assign them to a particular segment, but some tentative conclusions can be drawn nonetheless.

Documented midwifery entrepreneurial activity, for example, features largely in three of these segments (1,4,& 5). Those falling into segment 1 (public provision, public finance and public decision making) are the intrapreneurial midwives working within government provision such as the NHS and Sure Start. . The entrepreneurs - independent midwives are typically located in segment 5 because they at the present time they are primarily self-employed private providers of maternity services, privately financed by individual consumers who individually choose to opt for their care. This is an area in which patient choice, at the level of the individual who consumes this from of care, appears to clearly be enabled by the entrepreneurial activity (a question this review was asked to consider). However, although a few practices operate ‘sliding scales’ in fees according to the client’s ability to pay, the operation of such user fees

do have implications for access to, and equity in, choice of provider and care model. One well documented self-employed midwifery practice in London – *the Albany*, demonstrates a different, segment 4, category of entrepreneurial activity. In this model there is private provision but the financing comes from the public sector in the form of sub-contracting from King's College Hospital Acute Trust, which also makes the decision on behalf of the consumer. Advocates argue that such a contracting model enables the best of the independent sector (high emphasis on 'woman centred' care, continuity of carer, home birth, midwife satisfaction) while opening access to all regardless of income. The Independent Midwives Association (IMA) has proposed a NHS Community Midwifery Model along these lines which would enable independent as well as NHS employed midwives to use NHS facilities and to provide continuity of carer for all women (www.independentmidwives.org.uk). It argues that this model would sit alongside, rather than replacing existing models, thereby 'increasing choice for women' and helping to meet the aims of the Maternity Standard of the National Service Framework (DoH 2004) in which choice is also a central theme.

It appears there is the potential for entrepreneurial activity to also fit within segment 7 although this is poorly documented and we found only one example (Milan 2005). Activity within this segment could be where an independent midwife needs to take a mother into a public sector hospital either in an emergency situation or because the mother wants a hospital birth. To facilitate this activity the independent midwife may have an honorary contract status with the NHS hospital with the NHS. There is however no guarantee that such contracts will be issued (Hobbs 1997: 46).

Documented clinical nurse specialist entrepreneurial behaviour and NMHV offering complementary therapies falls in segments 1 and 5. Those falling into segment 1 (public provision, public finance and public decision making) are the intrapreneurial nurses and health visitors working within government provision such as the NHS and Sure Start. The entrepreneurs – the privately practicing specialist nurses or NMHV complementary therapists are located in segment 5 because they are primarily self-employed private providers of nursing or complementary therapies, privately financed by individual consumers who individually choose to opt for their care. This is an area in which patient choice, at the level of the individual who chooses this form of care, might be enabled by the entrepreneurial activity. However, unlike midwifery there is no evidence as to which individuals purchase specialist nursing or NMHV complementary therapists or why they decide to purchase these services.

In the UK there are a number of different combinations of public and private financing of, decision-making, and provision of health care (Burchardt et al 1999, Keen et al 2001) already in play. Nurse entrepreneurs providing accommodation with nursing or other health care services are private provision purchased with public or private finance, through both individual and public decision making. The documentation identified in this scoping on N,M, HV enterprise in this arena did not give sufficient information to analyse which configurations prevailed or the contribution to patient choice.

General practice services have always been independent businesses contracted to the NHS by a public body decision although the decision to use a particular service is within the domain of the individual. The small number of nurses becoming partners in general practice or holding PMS contracts as discussed in more detail in section 4.4.5. fall within segment 4 as reflected in the analysis in table 4.1. Similarly the small, but well documented, number of nurses involved in new forms of business arrangements , which are tendering (as documented in section 4.4.5) for APMS and SPMS contracts for the provision of personal medical services and community nursing and therapy services, would fall within segment 4 of the Burchardt model.

The English policy commitment to develop a supply side market of providers of primary care services (DH 2006) would suggest that increased level of provision will sit in segment 4 (privately provided) rather than its current position in segment 1 (publicly provided) . However, it remains to be seen the extent to which NMHV lead the development of enterprises and successfully tender for contracts in this market. Commentators offer scenarios of provider cartels in which practices are bought up by a single corporate entity, or local markets are dominated by single GP led companies prevail (Smith, Ham & Parker, 2005b) that are unlikely to see solely NMHV led enterprises flourish. Sketchy though the literature is nurse enterprise activity in primary care contracts, our analysis would suggest that it is likely to be a minority activity. In section 4.4.5 we raise the questions as to which environmental conditions are more likely to see successful nurse enterprise in this market and note that early indicators point to less than supportive environments in some areas.

‘Patient choice’ would sit, in Burchardt et al’s analytic figure, in the ‘outer circle’ of private decision-making. But the concept in itself is far from straightforward. As highlighted in a previous review commissioned by the NHS-SDO, as well as by the participants in our own expert seminars, ‘patient choice’ can be a slippery and contested term (Fotaki et al 2005).

One way to approach this is to look at how the entrepreneurs themselves and those who write about them, see their role in relation to any objective of facilitating 'patient choice', and it is to this analysis that we turn in the section that follows.

4.6 Aspirational claims made in Nursing, Midwifery and Health Visiting Entrepreneurship documents

To investigate where any aim of improving patient choice might sit within the range of objectives of entrepreneurial activity in these occupational groups, in our third analytical cut of this literature, we examine the 'aspirational claims' - the statements that are made in the documents about what the NMHV entrepreneurial activity is expected, or intended, to achieve.

As we have already indicated, there is as yet little detailed research on nursing entrepreneurship in the health care area. There has, however, been some recent research drawing upon economics, social policy and social psychology to understand independent provider motivations within the social care area (Wistow et al 1996, Knapp et al 2001, Kendall et al 2002) where the third sector and the private sector are majority care providers. In order to construct a framework for categorising the claims in the N,M, HV entrepreneurship literature we therefore drew upon this work, specifically upon the range of motivations expressed by the owners of domiciliary care homes for the elderly, documented by Kendall et al, (2002). Through an iterative process the elements of the framework were tested against the documents and further refined.

The framework consists of four main 'ideal types' of aspirational claim: 'professional', 'financial', 'mercantile' and 'empathetic'.

- **Professional** aspirational claims are those claims that the entrepreneurial activity will allow development of, or greater use of, skills and expertise (to achieve further professional accomplishment, greater creative achievement and so on).
- **Financial** aspirational claims concern how the activity will enable the generation of a satisfactory level of personal income and / or profit maximization.
- **Mercantile** aspirational claims concern the entrepreneurial activity's capacity to satisfy the entrepreneur's aspirations for independence and autonomy.

“Merchants” in this sense are those service providers who are motivated by the possibility for exerting control over their own affairs, and who value the sense of independence and autonomy which comes from running a small business.

- **Empathetic** aspirational claims are those claims that the activity meets the needs of a user group. For the purposes for this analysis we have subdivided this classification into three:
 - claims of improving **patient choice**
 - claims of improving **equity** and/or **access** to a service
 - **other** empathetic aspirational claims about user centeredness /duty / and responsibility (for example, in midwifery documents claims for ‘woman-centred care’ and for ‘building personalised relations with women’)

The purpose of this level of analysis is not to make any judgement about the validity or otherwise of any ‘claim’ but in the first instance to document and categorise *what is being said about* N,M, HV entrepreneurial activity.

The findings presented in table 4.4 are derived from a total of 104 documents relating to NMHV entrepreneurship in the employers and self-employed categories¹³. Half of the documents (n=51) in table 4.4 come from the primary care literature and half concern midwifery activity (n=53). Just as the motivations of many entrepreneurs in healthcare are multiple, so there are also multiple claims made for particular activities in some of the accounts.

¹³ The ‘fuzzy’ boundaries of ‘intrapreneurship’ mean that material on this activity was drawn on only for illustrative examples and it was not included within the NMHV entrepreneurship documentation ‘core’ (see chapter 1 for search criteria). Relevant additional information on this area is provided in illustrative footnotes and not in the ‘counts’ presented in table 4.2.

Aspirational Claims	Count	as % of claims made
Professional	38	24%
Financial	10	6%
Mercantile	51	32%
Empathetic : Improving patient choice	32	20%
Empathetic: improving equity/access	5	3%
Empathetic: other	22	14%
No claim made	24	15%

Table 4.2. : Aspirational claims for NMHV entrepreneurial activity

Interpretation of these figures must be cautious for a number of reasons. Firstly, the documentation, as described in the methods chapter, is diverse of very variable quality and detail. Secondly, the literature we identified in a broad and rapid scoping exercise may reasonably reflect what has been written in the last decade about NMHV entrepreneurial activity in the UK, but it does not necessarily proportionally reflect actual entrepreneurial activity – some areas may be over-documented and other areas may go largely undocumented (documentation of entrepreneurial nursing activity within the acute care sector, for example, is very sparse). Thirdly, there is the issue of interpretation. It seems likely that the expression of some aspirational claims – those expressing altruism for example, - may be felt to be more in keeping with the public image of the health professions than others (e.g. those expressing financial aims, see Chapter 5).

Despite all these caveats, a relatively crude analysis of this kind does render some interesting pointers to inform a future research agenda.

‘Mercantile’ aspirational claims were the most commonly expressed in this core literature on entrepreneurial NMHVs, and these featured in over 45% of the primary health care related documents. The entrepreneurial health worker’s desire to be autonomous, to organise their own work and to be responsible to themselves is a thread that runs through much of the documentation. ‘Professional’ aspirational

claims accounted for about a quarter of claims. For example, documents claimed that the entrepreneurial activity allows greater use of the nurse's or health visitor's skills, to develop new expertise or allowed the midwife to practice 'true midwifery'. Participants involved in the expert seminars made both mercantile and professional claims for their entrepreneurial activity. For example, one participant described how the desire for job satisfaction was a 'push' factor in them moving out of the NHS and starting to work independently.

'And I think, when I first came, started working independently, it was because I wanted job satisfaction. I was so fed up with doing the job, where I knew I had knowledge and skills that nobody was using, I wanted to be able to use that and be satisfied in what I did'.

'Financial' aspirational claims were the least commonly expressed, featuring in only one midwifery related and nine nursing and health visiting related documents.

About one fifth of the documents contained aspirational claims for the entrepreneurial activity that related to improving 'patient choice' in some way. Notably, this claim was a particularly strong theme in the midwifery literature where it featured in just over 50% of documents. This may reflect the maternity field's longer history of pressure for increased user choice of care model and of place of birth from both user and professional groups. By 1993 'choice' was set out as a key aspirational theme at the level of government policy with the 'Changing Childbirth' report (DoH 1993). The making of the claim in the entrepreneurship literature also highlights the extent to which the move of a small but vocal and determined section of midwives into independent sector activity was an explicit act of resistance to the 'predominant ideology of medicalised childbirth' (Hunter 1998). Entrepreneurial midwifery makes claims about improving choice for mothers in any or several of the following ways: in choice of care-giver, choices in type of care model and philosophy of care, and in choice around of location of care particularly expanding choice to include home birth (Hobbs 2001).¹⁴

¹⁴ The elasticity of the notion of 'enabling patient choice' was highlighted in the expert seminars. Some participants felt for example, that a midwifery group practice can be said to 'offer choice' if it encourages women to breastfeed where they would not perhaps otherwise. 'Choice' could also mean 'allowing' the opting out of care - not going to a GP, not having a cervical smear or not welcoming a health visitor into one's house. 'Patient choice' could explicitly mean the creation of services that are more responsive to

Although few documents outside of the midwifery literature made the claim that the entrepreneurial activity they described was enabling patient/ user choice, most participants in these seminars did feel that their own activity extended choice for patients - whether by offering a specialist nursing service, through offering complementary therapies or psychotherapy, or through service redesign (for example nurse-led medical services). Some providers of indirect services - typically those offering training in new skills areas – also felt that ultimately they, too, were contributing to increased patient choice.

In the documents concerning entrepreneurial services providing home birth care we found an intersection between claims for improving patient choice and specific claims about improving access to underserved groups. But aspirational claims around improving equity or access to direct care provision do not otherwise seem to have been commonly made for M, M, HV entrepreneurial activities in the UK so far. In contrast, improving access to services and addressing inequalities would seem to have been a dominant feature of the claims made in reports of activity undertaken by 'intrapreneurial' nurses, midwives and health visitors working inside the NHS¹⁵.

4.6.1 Aspirational Claims and the Evaluation of Outcomes

The scoping suggests that very little is known about the impact of existing NMHV entrepreneurial activity. Table 4.3 indicates how few of the aspirational claims made in the documents were then measured for impact¹⁶: 5 documents in the core 104

patients, for example a GP practice in Leicester that had opening hours to fit in with shift patterns of the local population at a car plant – 'it was purely respect for the patient base.... Nobody's ever made a fuss about it and it was a remarkable piece of just being responsive'.

¹⁵ Some 20 of the 25 sample documents about intrapreneurial activity in primary care, for example, stated that they aspired to improved equity or access to care.

¹⁶ We found considerably more attempts at evaluation of aspirational claims in the intrapreneurial NMHV literature. For midwifery activity for example, clinical outcomes measured including intervention rates (spontaneous labour, transfer to hospitals; home births, CS rates) and breastfeeding rates (Rosser 2003; Milan 2004; Benjamin, Walsh & Taub 2001; and Davies 1996). Women's views on choice, and control and views of themselves after birth (Rosser, 2003; Davies, 1996; Walsh 1999; Allen et al 1997; Milan 2000; Milan 2004). Documents report evaluations of the relationship between the midwife and the mother (Benjamin, Walsh & Taub 2001 and Walsh 1999), and stress and burnout in staff (Sandall 1997) and midwives' and mothers' views of working in midwifery group practice development projects (Allen et al 1997).

documents concerning entrepreneurial activity reported some sort of evaluation of activity in relation to the aspirational claims made for it (Milan 2005; Milan 2003; Walmsley 1998; Chapple 2000 and Naish undated).

Aspirational Claims	Count	Outcome measured in relation to claim
Professional	38	0
Financial	10	1
Mercantile	51	0
Empathetic : Improving patient choice	32	3
Empathetic: improving equity/access	5	0
Empathetic: other	22	1
Total	158	5

Table 4.3 : Frequency of the evaluation of claims

Of those studies of NMHV entrepreneurship that did attempt to measure the actual enactment of the claims, one reported on the financial outcomes. This account reported company turnover, maps onto a profit maximisation claim. The case study (Naish undated) of Ann Rushforth , Founder of Scotnursing, a nursing agency providing staff and training, reported in 2006 an annual turnover of £10 million.

Three studies made limited evaluations of the impact of the entrepreneurial activity on patient choice. Chapple (2000) evaluated patients' perceptions of two nurse-led pilot schemes that had been running for two years. Through qualitative interviews with 28 patients the author found that patients perceived nurses were as knowledgeable as doctors and patients 'felt they had real choice over who they consulted with. Walmsley (1998) reports on care provided by the independent midwifery centre, the Wessex Maternity Centre, and assesses the choice given to women about the place of birth, and reports data from routine audits on rates of pain

relief, transfers to hospital and water births. Milan (2005) similarly analysing 717 women's records to compare the care provided by independent midwives belonging to the Independent Midwives Association to other published studies of caseload midwifery practice. One study made measured claims relating to empathetic other. A very small study by Milan (2003) provides qualitative data on 'support and depth of trust' in the relationship between midwives and women.

The almost complete lack of good process and outcome evaluations – the lack of answers to the question of 'what works for whom, in what circumstances' (Pawson & Tilley 1997) is a substantial deficit in the existing literature on NMHV entrepreneurial activity in the UK. This deficit came as no surprise to the seminar participants. In the seminars it was questioned as to whether outcome measure is 'really relevant' in a market system 'as if you have got something to offer in the way of a service / product / care then as an entrepreneur you will survive'. However a few participants were enthusiastic about outcome measurement as a marketing tool even though there is a risk that results of such an audit may not show entrepreneurial activity to be working well.

4.7 Conclusion

We have mapped intra and entrepreneurial activity of NMHV in the UK and used this to create a typology which needs further refinement through empirical investigation. The categorisations, by type of service, by configurations of public and private provision, financing and decision-making, and by aspirational claims made for the entrepreneurial activity each offer complementary conceptual maps for understanding a very diverse range of intrapreneurial and entrepreneurial activities undertaken by NMHVs. They also facilitate more detailed examination of some aspects of the contexts within which entrepreneurial behaviour by NMHVs occurs.

The extent of intrapreneurial behaviour by NMHV and the conditions under which it thrives is difficult to extrapolate from a wider and more general literature on innovation and change. We have identified some groups such as health visitors where the culture of the professional role is to be entrepreneurial although the extent to which hierarchical organisations support or inhibit the entrepreneurial activities is also explored. We hypothesise that the public sector organisations are more likely to support intrapreneurial NMHV activity when it coincides with other agendas or is supported by central government policy and ring fenced monies.

We have identified a wide range of NMHV entrepreneurial behaviour in indirect health services and in direct patient care . However, the numbers of NMHV appear small in comparison to the scale of those registered as NMHV or when compared to other professionals or business people operating in these sectors. The literature would suggest that many of these types of NMHV experience similar triggers, drivers and inhibitors as women entrepreneurs although there are more specific triggers for some NMHV groups. For example, independent midwives appear to have more specific barriers e.g. indemnity cover. Another example is the legislative changes to allow different types of service providers to hold NHS contracts has created opportunities for some NMHV such as in primary care. These opportunities for NMHVs are incidental rather than a direct policy initiative aimed at NMHV business and as our scoping demonstrates, a number of unanswered questions remain not just for NMHVs but for health professionals as to the extent these opportunities will be successfully taken up.

The analysis by documented aspirational claims suggests that while addressing patient choice featured as an aim for some NMHVs other aspirational claims such as for independence, autonomy and opportunity to use professional skills featured more frequently. Even amongst these more frequently made claims however, there was very little measurement as to the actual impact of entrepreneurial activity. As we noted, much of the literature we examined was not objective and leaves many gaps and questions. Throughout this chapter we have raised these issues and return to them at the end of the report after we have considered the findings from our expert seminars that are not considered in the literature.

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Chapter 5 The Expert Seminars

A key objective of this study was to find out about ways in which nurses, midwives and health visitors are behaving entrepreneurially. As specified in the commissioning brief, our main approach to doing this has been through scoping the relevant published and grey literatures. However, as in any area of activity, it was clear from the start that the written accounts would contain an incomplete account of what is actually going on. Even in fields that have been extensively researched, where written dissemination of findings is a normative expectation, it is well known that studies with favourable or significant results are more likely to be written up and published than those without such findings (Song et al 2000; Cronin & Sheldon 2004). In the present case, as the preceding chapter demonstrates, relatively little formal research has been carried out. Behaving entrepreneurially is something people *do*, but may have neither time nor motivation to write about unless there is a good reason, such as something successful to celebrate. Consequently those accounts that do find their way into the literature tend to be selective, both in what aspects of entrepreneurship they cover and how these are discussed. The prevalence of 'hero' literature in this field, noted earlier, is a case in point.

The two expert seminars that we held towards the end of the study provided some opportunity to triangulate the findings from the literature review. (Details of the procedure are found in chapter 1 and a participants list is provided in Appendix 1.5.) The facilitated discussions enabled us both to test our emerging analysis, by confirming or challenging the findings we presented, and to extend it, by raising new issues that did not feature in the literature we reviewed. In the event, much of what was said in the seminars did reflect and reinforce the picture obtained from the literature. Where seminar participants expressed views that confirmed, challenged, elaborated or illuminated issues identified in the literature, these views have been noted and incorporated at the relevant points in earlier chapters. Where, in one or two cases, they told us about further examples of entrepreneurial activity not already identified, these have been taken account of in the analysis. The present chapter focuses on those aspects of NMHV entrepreneurial behaviour and experience that emerged in the seminars as relevant to understanding the nature of this activity, but which have not been mentioned elsewhere in our review.

Some of the issues that arose in the seminars were not commented on either in the broader management literature on entrepreneurship discussed in Chapter 2, nor in

the material specifically relating to NMHV entrepreneurial activity reviewed in Chapter 4. For example, while entrepreneurial activity has been characterised in the literature as 'mouldbreaking' and 'risk-taking' (Austin, Stevenson & Wei-Skillern 2006), less is written about how those who act entrepreneurially view themselves. Most of the seminar participants clearly saw themselves as in some way 'different' from other people in the health service – 'mavericks' or 'misfits' who don't fit into boxes and who might be perceived by others as 'mad' for the risks they willingly took. Various accounts were given of the kinds of things they enjoy, including: exposure to different ways of thinking and new ideas; a variety of work; being their own boss; exercising their own judgement; and having the confidence, arrogance and self belief to succeed.

As one person said,

"I remember when I was just, just qualified and two months later I was applying for a charge nurse post. And...I was called to interview and they said, 'well you've only just qualified,' and I said, 'but I can do it'. So they gave me a deputy charge post. So I was able to accelerate."

And another participant confirmed,

"I did exactly the same thing. Really arrogant! Very arrogant. I knew what I wanted and I knew what I didn't want to do."

This sense of exceptionality may help explain how these individuals had overcome various factors that they identified as liable to constrain other people working in the NHS from leaving it for independent practice or, having done so, from remaining outside. As already noted, there are many 'pull' and 'push' factors mentioned in the literature that may set people off down an entrepreneurial path, whose significance our participants confirmed. These include, for example, the ambition to innovate, the perception that opportunities for individual creativity are severely limited within the NHS and the belief that real change can therefore only be achieved by stepping outside. But much less is written on the reasons why people may feel unable to embark on such a route. The main 'restraining' features identified in the seminars as making the NHS 'tough to leave' include, first, not knowing how to function effectively outside the public sector. For example, one participant felt they lacked the commercial knowledge that would be needed to move out of the NHS and set up independently:

“...even though I come from a family of business... my father was in business, my brothers too... I lived with this - them talking profit margins and all of this - but I trained as a nurse, I trained in the public sector and I have the wish to provide the best care I can. And while I always would fit myself into the organisational entrepreneur - I would push the boundaries - but within the safety of an organisation. And that’s how those of us that do that get so frustrated, because I don’t know how to make that next step.”

A second restraining factor that was widely acknowledged is the protection the NHS provides for its employees. As one person noted, ‘inside the NHS it’s the organisation that takes the risk’, and participants saw this as something that an entrepreneur must have courage to relinquish. By the same token, the NHS was seen as offering the back up of a secure respite if things went wrong on the outside. Some participants talked about having worked entrepreneurially, but not in a ‘sustainable’ way - either for their own wellbeing or that of the project they were working on – and so they had gone back to the NHS. Going back in, albeit perhaps temporarily, was described as ‘giving you the opportunity to recover’ and ‘the space to think again’. Because of this option of return, particularly for those with clinical skills that are in short supply, NMHV entrepreneurial careers in the UK context may have more of the nature of a ‘revolving door’ than the serial progression earlier described as characteristic of entrepreneurs in some other contexts.

Besides these deterrents to breaking out of the NHS, other aspects of the current climate were noted as diminishing still further the already limited opportunities for *intrapreneurial* behaviour while remaining inside, and thereby preventing people from ‘cutting their teeth’ or obtaining a ‘taster’ of innovation. In particular, repeated service restructuring was seen as demoralising and discouraging, because any new venture would be likely to be cut short. The frequent reshuffling of middle managers that accompanies continuous reform was also highlighted as an impediment, because:

“How do you sell your ideas, products, services if the people who have the authority to say ‘yes’ keep changing? How do you get to ‘yes’ when the person says, ‘maybe’ and then you think you’re going to get them to ‘yes’, and then - ‘oh, hello, who are you?’”

Other ‘restraining’ factors identified were associated with the professional, rather than organisational, context of health care practice. Some of these are mentioned in the literature and have already been referred to. For example, participants commented

on a perceived lack of confidence and unwillingness to take risks among NMHV practitioners, which they attributed to professional socialisation. Further problems not alluded to in the literature included the difficulty of gaining space to develop entrepreneurial activities in an environment already hedged about by established interest groups in which medicine dominates. In primary care, for example, it was observed that while the GMS contract should theoretically have opened up new opportunities for NMHV entrepreneurial activity, it had not actually done so. Various explanations were suggested: that professional groups often block each other's options in order to defend their own territory, rather than working collaboratively, thus GPs try to block encroachment by nurses; that the GP practice model is taken as a given and prevents other developments emerging. The BMA was also cited as a significant obstacle, since it sets down conditions of employment for doctors and is very 'inflexible' about what is done. One further limiting factor associated with the professional context was the fact that the NMHV workforce in the NHS has an expectation of good occupational pensions. Against this, the need to organise a private pension if one went independent was seen as a significant deterrent.

There were also some issues discussed in the seminars that do feature in the broader literature on entrepreneurial behaviour, but were not alluded to in the NMHV literature reviewed. One concerned motives for working entrepreneurially. As discussed earlier, various claims are made in the NMHV literature about why people undertake these activities. These claims fell within four categories – professional, financial, mercantile and empathetic. Within the literature, financial reasons were least often mentioned and making money hardly featured at all. However, in the seminars there was general agreement that making money was a significant aim, though not necessarily the main objective,

“As I’ve got on, and eight years down the line, and I’m earning quite substantially, a lot of, more of it, is motivation to earn. But it’s all still about developing people and...actually helping other people.”

For a minority of participants, financial gain was acknowledged as a key driver:

‘Well I have to say I work seven days a week. I work seven days a week every week. I’m on call 24 hours a day unless I have a holiday. And the thing that motivates me, that drives me, is the money.’

Participants suggested that this element might be missing from the literature because it is not seen as an appropriate motive to admit to, or alternatively because it is taken as given and therefore not necessary to acknowledge.

When talking from their own experience about the skills and support needed to function successfully as entrepreneurs, seminar participants reiterated many of the issues raised in the literature but also identified some additional topics. The acquisition of business skills and contacts was seen as crucial (as also acknowledged by the RCN Congress in its 2006 resolution to develop practical support for nurses working as entrepreneurs (www.rcn.org.uk/news/congress/2006/20.php)). Participants confirmed the value of formal business networks for women, as highlighted in the literature on women as entrepreneurs, and of more generic networks, such as the Federation of Small Businesses and Business in the Community. They also emphasised the importance of mobilising informal connections to access the additional skills and contacts of, for example, 'the lawyer that lives next door' and 'the doctor who happens to be in the Department of Health, who lives down the road'. Such networking was seen to demand a rather different type of courage than was usually required in NMHV professional work. One participant recalled having behaved like 'a complete tart', when originally starting up in business, 'always asking somebody a favour'. Others identified the need for acute 'political' skills to negotiate across conventional organisational and professional boundaries and establish the relationships necessary to facilitate their work, particularly in roles such as health visiting, where the job depended on establishing links with agencies in the local community beyond the NHS and formal health care.

An important additional role of all these different types of networks was to counteract and protect against the isolation identified in the literature and confirmed by seminar participants as a potential downside of independent entrepreneurial practice. This 'professional loneliness' was widely experienced, and was seen as a key reason why some NMHV entrepreneurs return to working in the NHS. It was perceived to be a particular hazard for certain groups such as aesthetic nurses, who risk ostracisation by the rest of the nursing profession for the 'unworthy' nature of the work they did (dealing with Botox etc), despite the existence of a clear market for their services.

As mentioned at the start of this chapter, much of what was said in the seminars confirmed and reinforced the findings of this scoping study from other sources. And in many respects the participants echoed the upbeat tenor of much of the literature

reviewed, being very positive about their experience of entrepreneurial activities and the actual and potential contribution of this type of work. The present chapter has focused specifically on those areas discussed by participants that have not come up elsewhere and, through doing, so paints a slightly different picture. Specifically it draws attention to some of the difficulties and challenges that may prevent people embarking on, succeeding in or sticking with NMHV entrepreneurial practice in the present context. This more cautionary perspective is important to take account of when considering areas for further research, especially if there is a continuing presumption within policy that entrepreneurial behaviour is something to encourage.

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Chapter 6 Summary and discussion of findings, limitations and questions for further research

This chapter begins by outlining the main findings and discusses these in the context of current health policy and the organisational context in England, goes on to identify the limitations of the scoping and finally identifies a number of questions for further research which are raised by the study. The research questions are grouped into themes and each is linked to the relevant chapter and section of the report.

6.1 Summary of findings and today's context

Since the main part of this study was undertaken (Sept 05 to April 06) the effects of major and unanticipated financial shortages within the NHS have given rise to new priorities in the day to day running of the service. Debts of between £600m and 700m have been predicted for the past financial year, and some 7,000 NHS jobs were lost in March and April, with the Royal College of Nursing predicting that up to 13,000 more would go. At the time, the health secretary blamed poor financial management by a small proportion of NHS trusts for the debts. Her critics, however, claimed that government reforms involving miscalculation of the salary costs for NHS staff were likely to be the real cause (Batty 2006). This view is supported by the Department of Health's subsequent announcement that new contracts for doctors and nurses had cost £610m more than expected. We have witnessed a significant change regarding nursing recruitment, moving from the 'crisis' of shortages in 2005 to redundancies and lack of jobs, according to the RCN, for 4 out of 5 nursing graduates within 6 months as the most overspent NHS trusts have been required to balance their books within the financial year (RCN 2006).

In the quickly changing NHS, it is hard to predict how such financial problems might interact with the promotion of nurse entrepreneurs by the government and with the forces (such as redundancy) that lead individual nurses to consider setting up in enterprise. Interest in the concept of nurse entrepreneurship has continued, at least so far, within this new context. At the RCN's Congress in April 2006, a resolution submitted by nurse executives called for that organisation to develop practical support for nurses working as entrepreneurs. (The Nurse entrepreneurs group is a sub-group of the RCN Nurse Managers Forum.) A summary of the debate reveals discussion of the same issues raised within the literature and by the participants discussed in this report, for example the possibility of a contradiction between profit

motivation and motivation to provide 'good care', and the frustration of nurses trying to deliver a service in a satisfying way within the constraints of the NHS. The motion met with support of delegates.

In July 2006 a special issue of the journal *Primary Health Care* (Duffin 2006) included a journalist-written feature on nurses and social enterprise, including reports of the health secretary's promotion of the notion through her praise of a number of the initiatives already detailed in this report. The feature itself is even-handed discussing the possible negative implications of, for example, the failure of the Department of Health to fund a second cohort of students on the course at the Skoll Centre for Social Entrepreneurship in Oxford discussed in our report. It also brings up the implications of opening up a market for healthcare provision without special support for newly formed enterprises by nurses. This could lead, the article suggests, to more healthcare provided by large corporations, and the failure of smaller, potentially nurse-led initiatives to penetrate this market. Other problems for nurse-led enterprises include viability, sustainability, workforce security and pension issues.

In spite of these unresolved issues, and despite sustained opposition from within the NHS workforce (for example the industrial action over the proposed move of NHS logistical activities to the private company DHL) and the ranks of the Labour government, the current administration continues to promote contestability and plurality of healthcare provision, and to challenge the more traditional 'monolithic provider' models of health and social care. Interestingly, these moves are being challenged by the Royal College of Nursing (see chapter 4) at the same time as groups within that organisation are working to encourage a growth in the activities of nurse entrepreneurs. Social enterprise provision is being particularly promoted as an appropriate model for care delivery as it is said to allow great flexibility and innovation as well as add social value. It is considered by some to mirror many of the NHS values of patient-centredness and humanity of delivery. In terms of triggers to move into entrepreneurial behaviour, the promotion of social enterprise may well act, particularly for NMHVs in primary care as such a trigger, possibly in combination with growing employment insecurity already mentioned. It should be remembered, however, that a social enterprise model of healthcare delivery is not necessarily new. Nurses in public health have been involved in these types of activities for many years and only a few select examples are cited in the press such as the Nurse partnerships at Cuckoo Lane and Tipton practices or not-for-profit organisations such as Surrey Health.

The Social Enterprise Coalition (www.socialenterprise.org.uk) also actively promotes the role of social enterprises in the delivery of public services, claiming that they bring together the best of public and private sectors, the drive of business with a public service ethos. Its contacts with government are close, it has for example, recently published a pamphlet by health secretary Patricia Hewitt which sets out the advantages of involving social enterprises in the delivery of healthcare. Plurality of provider in primary and community care is particularly highlighted. Published in September 2006, it gives an indication of the present government's vision for the future of the UK health service (Hewitt 2006). To support this policy, NHS Networks are, at the time of writing, appealing for examples of commissioning of health and well being services jointly with other agencies and from the third sector (such as voluntary, community or self help organisations, or social enterprises) (<http://www.networks.nhs.uk/news.php?nid=1029>). The advent of primary care commissioning clearly enables and promotes such diversity of provider, as previously discussed in this report (see chapter 3).

This study has provided a conceptual map of the types of intra and entrepreneurial activities engaged in by NMHVs (chapter 4). Although we found a range of NMHV entrepreneurial activity in the UK, it represents only a very small proportion of NMHVs and former NMHVs engaged in these types of activities. In this it reflects most of the international literature, although there are some sectors e.g. midwives in the Netherlands for which the situation is reversed.

There is only modest agreement over the meaning of the term 'entrepreneur' in business and management literature. This does not help an understanding of the term 'nurse entrepreneur'. In some UK policy articulations, the term 'nurse entrepreneur' is used loosely, is ideological and actual examples given are often more accurately described as organisational flexibility or nurse substitution for medical roles.

The international literature on nurses entrepreneurs uses the term interchangeably with enterprise in some countries or uses completely different terms to describe self employed nurses and midwives or business owners (see chapter 2 and 4) . Informants within the expert seminars were more comfortable with adverb entrepreneurial, than the noun entrepreneur (see chapter 5).

The scoping took a broad view of definitions in order to include rather than exclude activity (chapters 1 and 2). However, it was noted that there were challenges in dealing with the overlap with literature on innovation and change (chapters 1 and 4).

The UK scoping was analysed by type of activity (chapter 4, section 4.4). It was noted that certain groups of NMHVs, such as those with public health roles or some clinical specialist roles, are more likely to be intrapreneurial. Consideration was given to the types of organisation or environment that might support such behaviour and to what extent any individual in an organisation was entrepreneurial in isolation from a wider group of people offering permission, support, or resources (chapter 4 section 4.4.3). Entrepreneurial NMHV activities were identified that indirectly contributed to health care such as knowledge transfer through training and consultancy, invention of healthcare products, and provision of infrastructure services to health care and self-employed and small business provision of direct healthcare services (chapter 4 section 4.4.4).

Some recent policy changes in commissioning in NHS primary care services and the creation of a supply side market through encouraging 'third sector' health and social care enterprise make new forms of NMHV entrepreneurial and business activity possible. Chapter 4 documents the limited extent of this type of activity by NMHVs at present, although in a rapidly changing policy and policy implementation environment there is potential for this picture to shift. It is not clear to what extent NMHVs will move from being employees of the NHS or general practice to being nascent entrepreneurs as employers in new types of social enterprise business or as business partners in general practice. Nor is it clear how nascent NMHV entrepreneurs will fare in competition for contracts in environments where many more entrepreneurs and businesses are established compared with large corporations who are becoming involved in tendering for this new business opportunity. We would suggest that these types of issues can only be understood in the broader context of other health professional groups, rather than focusing on NMHVs in isolation.

It is noteworthy that many NMHVs entrepreneurs who were either self-employed or employers had close relationships with the NHS. For some this was the source of their business, while others reverted to temporary employment when income levels dropped, moving out again because of dissatisfaction with the constraints of the NHS, and moving back in when self-employment was precarious. One expert informant described the NHS as 'the mothership', illustrating a perception of the NHS as a safety net in entrepreneurial risk. Therefore, the career paths of NMHV

entrepreneurs may be complex. Recent nurse redundancies and uncertain career prospects for nurses may lead to many considering self-employment on the edges of the NHS or well beyond it.

We are uncertain whether increased levels of NMHV entrepreneurial activity are likely in the future, though theoretically at least, the rising levels of nurse redundancy that we are currently witnessing will create a larger pool of potential entrepreneurs. The expert seminars tended to indicate that those NMHV that have left the NHS to set up in business on their own, in a largely hostile and unfavourable climate, are atypical of the greater NMHV workforce as a whole - exhibiting unusual persistence, individuality, risk taking and willingness to 'put their head above the parapet'. As these are classic characteristics associated with entrepreneurs this may be unsurprising, but their atypicality raises questions about the likelihood of increased numbers of NMHVs behaving entrepreneurially in this sector, which future research would need to explore. In addition, the great majority of the pool of potential NMHV entrepreneurs are women, and women take different routes, respond to different types of triggers, seize different types of business opportunities and experience different barriers to male entrepreneurs (chapter 2 section 2.6.13).

The connection between NMHV entrepreneurial activity and patient choice appears not to be strong (chapter 4 section 4.6) with the possible exception of independent midwifery. Increasing patient choice was stated as an aspiration in 20% of the documents we analysed. Aspirations concerning autonomy of practice and professional accomplishment were cited in approximately 55% of these documents. Financial motivations are not prominent in the literature but our seminar participants suggested this may be misleading because, they believed, talk of the profit motive is unacceptable within NMHV culture. It was noticeable that the documented aspirations of the sample of intrapreneurial NMHVs were focused on addressing issues of equity in provision and access for those poorly served by current arrangements – a policy imperative not explicitly linked with the patient choice agenda though present in other policy.

There is very little actual measurement (and therefore evidence) of the outcomes of entrepreneurial activity (chapter 4 section 4.6.1) . If entrepreneurialism is an area to be encouraged, good process and outcome evaluations are needed to find out what works - for example the importance of networks for entrepreneurs and intrapreneurs — as well as what does not work — and the circumstances in which NMHV entrepreneurialism is successful.

The theme of choice has a longer history in midwifery, with policy in the early 1990s encouraging choice for women in childbirth. However that increased choice is confined to a small number of clients, geographical access is restricted and currently user fees allow choice only for those who can afford to pay. Whilst there are independent midwives, there has not been an explosion in numbers because of the difficulties these midwives face. While they may have gained in terms of professional autonomy they have had to contend with barriers such as the difficulty of getting affordable professional indemnity cover. They have also struggled with hospital interface and alienation from other professional groups. More is written up in the literature although, as with the primary care literature, much is 'hero' reporting. Little is written in the way of measurement of outcomes. Further investigation of the midwifery experience might identify lessons for application to other professional groups.

Both the literature and our expert seminars revealed some of the obstacles to becoming entrepreneurial, and surviving successfully in those roles e.g. the importance of the wider context –the NHS in general and in its present state of flux, and the wider professional environment – both NMHV socialisation and NMHV work takes place within the power structures of the health sector overall. If the NHS itself changes (e.g. becomes less secure and supportive), then the balance of risk/safety, cost/benefit of staying in it versus leaving to be an entrepreneur will also change.

6.1.1 Policy implications of the findings

Intrapreneurship: Some intrapreneurial NMHVs are addressing patient and population group health care needs poorly served by current arrangements. Intrapreneurial activity is difficult to distinguish from innovative activity but intrapreneurial activity is most apparent in groups who are given organisational permission to innovate and where command and control hierarchies are less apparent. At the meso level of policy making, consideration needs to be given to how organisational structures can support rather than inhibit intrapreneurial behaviour that addresses both patient need and choice.

Primary care commissioning: if NMHV entrepreneurs are to be encouraged as one mechanism for promoting patient choice then specific treatment of NMHV entrepreneurial activity in the face of competition from large corporations may be required. Further research into the full extent of new NMHV entrepreneurial activity in response to recent changes in primary care commissioning is required.

NMHVs entrepreneurs are atypical of NMHV as a whole: if NMHV entrepreneurs are to be encouraged attention needs to be given to recruiting into these professions those with entrepreneurial leanings and providing support, skills training and network-building opportunities for this group.

Change in the NHS and entrepreneurial activity: continued change and restructuring, as well as current drives to reduce expenditure in the NHS are likely to inhibit entrepreneurial activity within it and on its edges.

6.2 Limitations of the study

We acknowledge two limitations within this scoping exercise. We primarily focussed our work on areas where we already understood that NMHV entrepreneurial activity was likely to be most predominant and in this way aimed to gather the greatest amount of information within a relatively short study. This led to a greater focus on primary care and midwifery literature. Accounts of NMHV entrepreneurial activity within the acute care and mental health sectors were far less prominent and it is likely that there is unexamined activity in these sectors. While we addressed our brief in that a comprehensive review was not required for this project it may be that there is further material to be revealed by further empirical investigation.

The second limitation is a result of the character of the literature on NMHV entrepreneurialism itself (chapter 4 section 4.1). Published literature provides only a partial account of any field of activity and this may be particularly evident within the topic of this scoping exercise. In scientific literature it is well accepted that a publication bias exists (Easterbrook, Berlin et al. 1991) resulting in a lack of published accounts of negative findings (even though there is potentially much to learn from them). The literature on entrepreneurial activity shows a strong emphasis on the heroic and successful and it is therefore even more likely that accounts of failed enterprises will not appear in this literature. Also, as our seminar participants reminded us, entrepreneurs tend to do rather than write so there is likely to be more activity than literature. In addition to this, the great majority of the literature that we did review was not conventional research literature providing (or aiming to provide) reliable, objective and systematic information about its topic. Rather personal narratives and journalistic accounts predominated. At best this limited the amount of information contained within the articles, at worst it meant that accounts were biased in ways that suited the purposes of the individual writers. It was because we recognised all of these problems with the literature that we ran the expert seminars.

Talking to people involved in NMHV entrepreneurial activity helped us to triangulate the information collected from the literature by raising our awareness of its biases and gaps. We have used the findings of the seminars in the text of our report where they link to issues that are raised in the literature and to extend, illustrate, expand and challenge it.

6.3 Summary of Research Questions raised in this report

The following research questions have been drawn from our analysis of the literature and escoping (Chapter 4) and discussions in the expert seminars (Chapter 5) and our identification of the gaps in available knowledge. Their breadth illustrates the paucity of information currently available across a broad range of issues of interest in the policy arena. We would suggest that while most of the focus is on NMHVs, empirical study would be enhanced by opportunities for comparative analysis with other healthcare professionals.

There are two major themes to the research questions raised by our research. The **first** theme concerns **benchmarking** and arises from the need to generate comprehensive knowledge about the current extent of NMHV entrepreneurial activity and its character. The **second** concerns investigations into those factors which are likely to **encourage or support** entrepreneurial or intrapreneurial activity. In the absence of any good evidence the focus of many of the suggested research questions is on establishing baseline information and these are grouped together as a theme so it can be determined what kind of effectiveness research can be undertaken and what kind of judgments can be made about NMHV entrepreneur effectiveness and how they affect care, outcomes and organisational delivery. In addition, further research/policy consideration will be better illuminated by considering NMHVs in the wider context of other intra/entrepreneurial health professionals.

6.3.1 Theme 1 benchmarking Intrapreneurial NMHV

Our policy analysis, literature review and the testimony of our expert panel all revealed a focus on the prominence of intrapreneurial activity by NHS employed nurses as a way that innovation could be developed. Also apparent, however, was the fragility of some of these initiatives in the face of withdrawal of funding or changes in employment of the instigators, meaning that any benefits were not

sustainable. Therefore the following questions are recommended for further research.

To what extent is any intrapreneurial activity in the NHS the result of one person's activity, drive, motivation? (chapter 4 section 4.4.2)

6.3.2 Entrepreneurial NMHVs

We know little about who NMHV entrepreneurs are. Knowing this could help to reveal the kind of support that they are likely to need if the Department of Health wishes to encourage such activity. Also, understanding their motivation will also help policy makers to ascertain how far the encouragement of NMHV entrepreneurs is likely to further the policy objective of the promotion of patient choice.

What is the age profile and years of health care experience of NMHVs moving into enterprise? (chapter 4 section 4.4.4)

To what extent does the NHS lose NMHV with significant clinical expertise to enterprise during periods of organisational turbulence and downsizing, particularly during the present year? (as above, chapter 5)

To what extent do clinically and managerially experienced NMHV develop portfolios of different types of work and income streams? (as above)

Is the career trajectory of male NMHV entrepreneurs the same or different to female NMHVs? (chapter 4 section 4.4.4, chapter 2 section 2.6.7)

To what extent are NMHV from black and minority ethnic groups represented in the entrepreneurial categories and are their career and entrepreneurial trajectories similar to NMHVs from majority ethnicities ? (as above)

Are the motivations, triggers and barriers any different for NMHVs moving into enterprise than other women in the UK ? (chapter 2 section 2.6.7, chapter 5)

Are the career trajectories of NMHVs involved in these types of enterprise similar or dissimilar to those of UK women or men entrepreneurs or to other types of NMHV intra/entrepreneurs ? (chapter 2 section 2.6.7, chapter 5)

6.3.3 Theme 2: What factors encourage and support NMHV intrapreneurial and entrepreneurial activity?

If the Department of Health wishes to promote NMHV entrepreneurs, as well as intrapreneurial behaviour in order to further the aim of promoting patient choice or for other reasons, it is important to have an understanding of organisational factors that are likely to promote this. The following research questions concern intrapreneurial activity.

Intrapreneurial activity

What are the key features of an NHS organisation that supports intrapreneurial activity by NMHVs? (chapter 4 section 4.4.2)

What factors external to an NHS organisation are likely to support or inhibit intrapreneurial activity by NMHVs? (as above)

Is there any link between the types of education, background and/or the level of seniority that supports intrapreneurial behaviour in NMHV ? (as above, chapter 5)

To what extent do the relationships with doctors and other healthcare professionals (and which types of relationships with which types of doctors and others) support or inhibit NMHV intrapreneurial behaviour? (as above, chapter 3, chapter 5)

Do NMHV roles that have clearly defined focus and boundaries encourage intrapreneurial activity on behalf of their client groups? (chapter 4 section 4.4.2)

Entrepreneurial NMHVs

NMHV entrepreneurialism has been promoted at times as if it is an unproblematic way to improve services and increase patient choice. Our scoping, however, found that this was not always the case and that unforeseen obstacles to successful entrepreneurial behaviour existed. Would-be NMHVs speak of encountering some hostility from those within mainstream services. In addition, NMHV entrepreneurs seldom formally evaluate their impact being concerned with delivery issues.

Therefore we know little about how effective, either clinically or in terms of achieving government policy objectives, the range of NMHV entrepreneurial activity is. To provide this information, we propose the following questions.

Are the failure rates of nascent NMHV entrepreneurs comparable to others setting up in business in the UK and what can we learn from 'failed' enterprises? To what extent is there hostility within the NHS to NMHV entrepreneurialism and does this contribute to some failure ? (chapter 4 section 4.4.4, chapter 5)

Can NMHV entrepreneurs be encouraged and enabled to systematically evaluate their outcomes? (chapter 4 section 4.6.1)

To what extent does the use of NMHV qualifications aid or detract from entrepreneurial activities ? (chapter 4 section 4.4.4)

To what extent do NMHV entrepreneurs create choice for patients or respond to known gaps in service provision ? (chapter 4 section 4.4.4)

To what extent do entrepreneurial NMHV have family or previous experience of the business world and to what extent do they have different personality traits to other NMHVs ? (chapter 4 section 4.4.4 C and chapter 5)

To what extent does the NHS encourage and support inventions by NMHV and deal with issues such as intellectual property rights ? (as above)

What types of local and national level support, by which types of stakeholders, enable NMHV to compete for contracts for mainstream NHS services ? (chapter 4 section 4.4.5 B)

Are multi-disciplinary tenders for APMS and SPMS contracts likely to be more successful than NMHV only tenders ? (as above)

Are the tenders offered by nurse led organisations for APMS and SPMS contracts different in any respect to those offered by other groups ? (as above)

To what extent do NMHV services directly paid for by the client offer something that is not available or not provided in an acceptable manner in the NHS ? (as above B)

If a policy goal is to encourage more NMHV entrepreneurs, what additional support is needed? And what is the environment for cultivating successful entrepreneurs?

What are the education and training needs to contribute to a growth in NMHV entrepreneurial activity? To what extent can the skills (such as political skills) be learnt on a course like Skoll? (chapter 2, chapter 5)

What are the options for managing conflict of interest issues in relation to commercial confidentiality and the transfer out of (and back in to) the NHS of entrepreneurial talent? How will this affect the cooperative versus competitive dynamic which such transitions imply? What lessons may be learnt from experience with the medical profession? (chapter 5)

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Appendices

Appendix to Chapter 1

The UK Nursing, Midwifery and Health Visiting workforce context

In 2005 there were 672,897 nurses, midwives and specialist community public health nurses registered with Nursing and Midwifery Council (NMC 2005), of these

- 503,728 (75%) were first level registered nurses only
- 43,064 are registered as midwives (although only 32,745 submitted ITPs for 2005)
- 29,000 were registered as specialist community public health nurses¹⁷

No one may practice as a nurse or as a midwife in the UK without registration with the (NMC) that has to be renewed every three years. In addition, midwives have to submit an annual 'Intention To Practice (ITP) ' form to the NMC.

The NMC statistical analysis showed eighty nine per cent of those registered were female (a 1% increase over 10 years), 60% were over the age of 40 and 77% resided in England (NMC 2005). From 1996 to 2000 an average of 18,000 people were added to the NMC Register annually, increasing to 30,000 annual additions after 2000. Approximately 3% left the Register annually between 1996-2005 (NMC 2005).

In the UK the majority of N,M,HV are employed in the NHS. Approximately 437,000 (headcount) were employed in 2005¹⁸ in comparison to the estimated 58,000 whole time equivalent registered nurses and midwives employed in private hospitals, homes and clinics in 2000 in England and Scotland (Buchanan and Seccombe (2003). A further 24,000 nurses were employed by general practice in England and Scotland¹⁹.

¹⁷ From 2005 The specialist community public health nurse part of the NMC register includes health visitors, schools nurse, occupational health nurses meeting a set of competency criteria.

¹⁸ All data in this section is compiled from 2005 NHS workforce statistics collected by NHS England Information Centre for Health and Social Care, ISD Scotland, Northern Ireland HPSS Information Analysis Directorate and Stats Wales.

¹⁹ Data not available in Wales or Northern Ireland

Characteristics of the NHS N,M,HV workforce

N,M,HV's, form around 30% of the directly employed NHS workforce, although they make up the largest clinical group. The majority work in acute, elderly and general medicine specialities as illustrated from English data on professionally qualified N,M,HV in Figure 1.

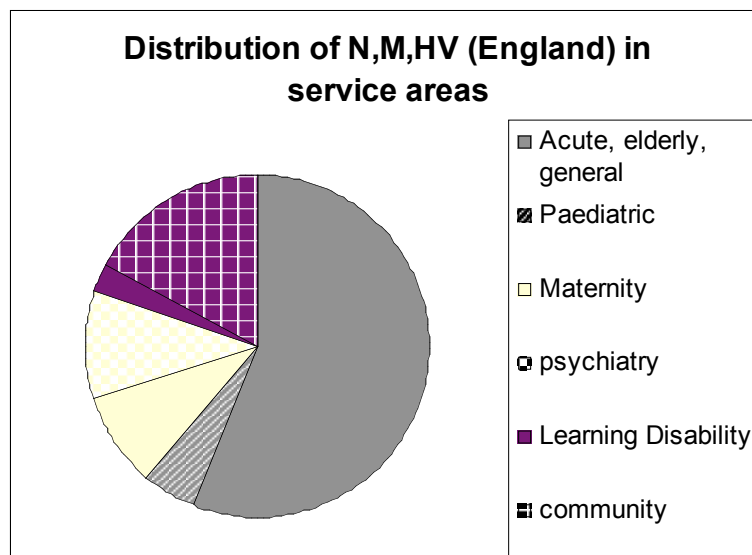


Figure 1.

Source NHS Information Centre for Health and Social Care NHS Hospital and Community Staff (HCHS): Non-Medical England: 1995-20052006

Although the majority of nurses are female (89%), the distribution of male nurses varies between service areas, for example, 35% of nurses are male in the psychiatry services but only 1.3% in maternity services. The ratio also varies according to position in the organisation hierarchy. While 1 in 10 N,M,HV are men, 1 in 5 nurse manager posts are held by men, increasing to 1 in 2 in services that employ more men e.g. community psychiatry services.

The age distribution also varies between sectors so while only 12% of the total N,M,HV working NHS are aged under 30, this rises to 15% in the acute, elderly and general medicine sector and drops to 10% in maternity services and 6% of registered nurses working in the community. The age distribution curve skews further in some segments of the primary care nursing workforce where 70% of health visitors and district nurse team leaders are aged over 40.

Many N,M,HV work part-time in the NHS as evidenced by the difference in head count to the full time equivalent . However this varies too between sector and gender. For example, in Northern Ireland , only 56% of nurses work full time hours in the NHS, but this rises to 89% in the mental health services and 74% in the district nursing services. It is also noted that 93% of all male nurses worked full time hours. (Northern Ireland Research and Statistics Department 2006)

The self declared ethnic background of the N,M, HV workforce is incomplete. In England the ethnic background of about 20% of N,M,HV is unknown. Of those whose ethnic background is known 19% are from minority ethnic groups, in which the two largest groups are identified as Black or Black British (over 23, 000) and Asian and British Asian (over 21,000). This contrasts with the NHS workforce as a whole which has 8% from ethnic minorities and the workforce of the UK economy (6.7%) as a whole (Wanless 2001) As with age and sex there is variation between service areas and positions in the hierarchy. About 20% of registered nurses, 12 %, of midwives and 10% of health visitors are from ethnic minority backgrounds. They are less likely to be represented in the positions of seniority with 6% of modern matrons and 7% of nurse managers from ethnic minority backgrounds.

Comprehensive data on turnover and exit from the NHS or N,M,HV workforce is harder to obtain. The Office of Manpower Economics undertakes an annual workforce survey as part of gathering evidence for the pay Review Body but points to the high level of incomplete data as a reason to treat the data with caution. In 2005 it reported from 164 Trusts in England and Wales and identified that the turnover rate i.e. those leaving as a proportion of staff in post was 11% in the NHS (England and Wales) (Review Body for Nursing and Other Health Professions 2006). Of these about 40 % had no reason for their departure recorded, but 9% were retirements, 8% were to employment outside the NHS and 22% were recorded as other including redundancy, career break, and personal reasons.

Characteristics of nurses employed in the UK independent health care sector

Information on the characteristics and demography of the N,M,HV not directly employed by the NHS is more difficult to obtain. While there is broad data on numbers of practice nurses employed by general practice there is no recent demographic data (Drennan 2004). The numbers of practice nurses, however, has grown enormously since early 1990s legislation such as the GP Contract offered enhanced financial incentives to GP for their employment. In addition, number of

independent midwives registered with the Independent Midwives Association is 115 as at 2006.

The demographic profile of the N,M,HV in the UK would indicate that it is necessary to understand the literature specifically about women entrepreneurs (see chapter 3).

Text of invitation to respond to escoping

Dear E group members

Subject: NHS funded Service Delivery and Organisation (SDO) Scoping project on Nurse, Midwife and Health Visitor Entrepreneurs and Patient Choice

As part of the above scoping study we are investigating past and current entrepreneurial activity among nurses, midwives and health visitors. The aim is to build a picture of the extent and types of entrepreneurial activities that N,M,HV's are involved in and to explore the implications for patient choice. By the term 'entrepreneur' we mean anyone who has recognised a nursing-related opportunity to start-up something new, has actioned that idea and seen it grow and develop either within the NHS or outside of the NHS. We know that these types of activities are not new for many N,M,HV's but feel few have been disseminated through conventional published literature.

We would be delighted to hear from anyone who is or has been involved in such initiatives.

Best wishes
Kathy Davis / Rachel Locke
Research Fellow

Tel 0207 288 3323
Email: k.davis@pcps.ucl.ac.uk

This is a collaborative project. Michael Traynor is the Principal Investigator from the Middlesex University. The team also includes: Vari Drennan from the Primary Care Nursing Research Unit, UCL, Claire Goodman from University of Hertfordshire, Charlotte Humphrey, Susan Murray and Rachel Locke from Kings College London and Annabelle Marks, Middlesex University Business School.

Appendix 2.2

E-scoping: List of websites searched.

Nursing related

UK

- The Royal College of Nursing UK <http://www.rcn.org.uk/>

International

- International Council of Nurses. <http://www.icn.ch/guidelines.htm>
- The Nurse Innovations Database. <http://www.icn.ch/innovations/>
- The Nurses in Business Organisation. <http://www.nnba.net/index.htm>
- European Nursing Leadership Foundation
www.nursingleadership.org.uk/home.htm
- The National Association of Independent Nurses
<http://www.independentrn.com/>
- The Nurse Entrepreneur Network <http://www.nurse-entrepreneur-network.com>
- The Nurses Medscape website <http://www.medscape.com>
- University of Tennessee <http://www.utmem.edu/nursing>

Entrepreneurship

General

- World Health Organisation Europe: Highlights on health.
<http://www.euro.who.int/eprise/main/who/progs/chhfra/home>
- The Global Entrepreneurship Monitor Programme
[http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F90003968DB/\\$File/GEM+Global.pdf](http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F90003968DB/$File/GEM+Global.pdf)
- Erasmus Research Institute of Management- The ERIM Report Series: Explaining Female and Male Entrepreneurship at the Country Level.
<https://ep.eur.nl/handle/1765/7172>
- Greenleaf Centre for Servant-Leadership
<http://www.greenleaf.org/leadership/servant-leadership/What-is-Servant-Leadership.html>

Female Entrepreneurship

UK

- The British Association of Women Entrepreneurs. <http://www.bawe-uk.org/>
- Prowess - UK association of organisations and individuals who support women to start and grow businesses. <http://www.prowess.org.uk/default.asp>
- Everywoman UK- leading provider of valuable, practical and relevant services to support women in business. <http://www.everywoman.co.uk/>
- DTI Small Business Service: Promoting Female Entrepreneurship
<http://www.dti.gov.uk>
- Barclays Small Business Survey Women in Business 2004
www.business.barclays.co.uk/bb/surveys
- British Chamber of Commerce - Women's Enterprise Steering Group
Achieving The Vision Female Entrepreneurship
http://www.chamberonline.co.uk/policy/issues/women/womens_entrepreneurs_hip.pdf

- The National Foundation for Women Business Owners. On the Move: Women and Men Business Owners in the UK www.nfwbo.org
- Women into the Network(WIN) www.networkingwomen.co.uk
- Scottish Business Women www.scottishbusinesswomen.com

International

- Development Fund for Women UNIFEM Gender Fact Sheet No.4. <http://www.unifem.org/>.
- EUROPA European Industry and Enterprise- The European Network to Promote Women's entrepreneurship(WES) [http://europa.eu.int/comm/enterprise/entrepreneurship/craft/craft-](http://europa.eu.int/comm/enterprise/entrepreneurship/craft/craft-women/wes.htm)

[women/wes.htm](http://europa.eu.int/comm/enterprise/entrepreneurship/craft/craft-women/wes.htm)

- Women Entrepreneurs <http://europa.eu.int/comm/enterprise/entrepreneurship/craft/craft-women/women-dgentr-activities.htm>
- Equal opportunities for women http://europa.eu.int/comm/employment_social/gender_equality/index_en.html
- Women in Business and Decision making- A Survey of Women Entrepreneurs co funded by European Commission [http://www.eurochambres.be/PDF/pdf_women_network/WiB%20Women%20f](http://www.eurochambres.be/PDF/pdf_women_network/WiB%20Women%20final.pdf)

[inal.pdf](http://www.eurochambres.be/PDF/pdf_women_network/WiB%20Women%20final.pdf)

http://www.eurochambres.be/PDF/pdf_women_network/WiB%20Chambers%20final.pdf

- Centre for Women's Research.(formerly the Foundation for Women Business owners) <http://www.womensbusinessresearch.org/mediacenter/2-28-2001/2-28-2001.htm>

Social Entrepreneurship

- Ashoka developed by Bill Drayton to develop and legitimize the profession of social entrepreneurship.http://www.ashoka.org/fellows/social_entrepreneur.cfm.
- The Kaufmann Foundation- Diana project http://www.kauffman.org/pdf/Diana_2004.pdf

Other

- National Statistics online Growth in self-employment in the UK. <http://www.statistics.gov.uk/cci/article.asp?id=986>
- International Labor Organisation. <http://laborsta.ilo.org/>

Footnotes

- **GEM surveys** analyse total entrepreneurial activity (TEA) defined as the share of adults in the population aged 18-64 who are actively involved in starting a new business or managing a business less than 42 months old.
- **Ashoka** is an international organisation that develops social entrepreneurial activities world wide.

- Founded in September 1999, **Everywoman Ltd** launched its first service, the website www.everywoman.co.uk. It was the first interactive website for women in the UK and is now the leading online network for women starting or growing a business. With over 100,000 signed-up members, everywoman.co.uk provides users with relevant information, appropriate services and additional resources
- **Prowess** is a UK network of organisations and individuals who support the growth of women's business ownership. Prowess has over 180 members who support 100,000 women each year to start 10,000 new businesses that contribute an additional £1.5 billion to the economy.
- The **Global Entrepreneurship Monitor (GEM)** research program is an annual assessment of the national level of entrepreneurial activity that was initiated in 1999. GEM is the world's largest and longest-standing study of entrepreneurial activity and is scaled on population not labour force in the formal sector rather than informal sector. The results of GEM data analyses are used as key benchmarking indicators by regional, national and supranational authorities around the world. GEM surveys analyse total entrepreneurial activity (TEA) defined as the share of adults in the population aged 18-64 who are actively involved in starting a new business or managing a business less than 42 months old. It two categories; the *nascent entrepreneur* an individual who has taken action and created a new business in past year and expects to share ownership but has not yet paid salaries and wages for more than 3 months, and *owner /manager* of a new firm that has paid salaries and wages for more than 3 months but less than 42 months (Reynolds et al. 2002)(GEM Monitor Executive Report 2002).
- **British Chamber of Commerce/GEM report** on Female Entrepreneurship 2004 An overview of the entrepreneurial landscape in relation to women in the UK. Contains indepth analysis of 3 years of GEM data from GEM and more than 60 case studies from the Chamber network.
- In the USA, **The Diana Project** (sponsored by the Kaufmann Foundation) is a multi-university, multi-year project that specifically dedicated to the study of women business owners and business growth.

[Online at]http://www.kauffman.org/pdf/Diana_2004.pdf

- **The European Network to promote Women's Entrepreneurship (WES)** is a network created on a Swedish initiative in October 1998 and launched officially in June 2000. This network is composed of 16 members, from all the countries of the European Union, except Luxembourg, plus Iceland and Norway. The delegates in the network represent central national governments and institutions with the responsibility to promote female entrepreneurship.
- **The British Association of Women Entrepreneurs (BAWE)**, the British affiliate to Les Femmes Chefs d'Enterprises Mondiales (FCEM), one of 30 affiliated countries from 5 continents linked to all chambers of commerce. Association has been in existence for over 50 years. Aim of association is to bring together women qualified to be called 'Heads of Business'(women who control or won a company whatever its size and crucially have capital at risk and are financially responsible for their business commitments).

Expert Seminar 3rd April 2006

Participants' List

Participants	Facilitators
<p>Margaret Buttigieg Independent Consultant</p> <p>Liz Cheshire Consultant/Clinical Specialist</p> <p>Stephen Clifford Registered Mental Nurse, Registered Nurse for Learning Disabilities, Counsellor and Psychotherapist</p> <p>Jill Demilew Midwifery Adviser Women's and Maternal Health Team Department of Health</p> <p>Nicola Easey Modernisation & Commissioning Lead for the NHS Alliance</p> <p>Ruth Grant Health Visitor</p> <p>Anne Hamerton Director of company that runs as an APMS.</p> <p>Martin Hunt Head of Service Development at the MS Society</p> <p>Abi Masterson Director, Abi Masterson Consulting</p> <p>Maureen Morgan Nursing Officer Policy & Planning – Primary Care Department of Health</p> <p>Debra Sharu Director, Practitioner Development UK Ltd</p>	<p>Kathy Davis Research Fellow Primary Care Nursing Research Unit Dept. of Primary Care and Pop. Sciences, The Royal Free & UCL Medical School University College London</p> <p>Rachel Locke Research Associate School of Nursing and Midwifery King's College London</p> <p>Susan F Murray Senior Lecturer Division of health and social care King's College London</p> <p>Michael Traynor Professor of Nursing School of Health and Social Sciences Middlesex University</p>

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Appendix to Chapter 2. On-line Resources for women entrepreneurship

Development Fund for Women UNIFEM Gender Fact Sheet No.4.
[Online] at <http://www.unifem.org/>.

The Cambridge- MIT Institute [Online at] www.cambridge-mit.org/cgi-bin/default.pl?SSSID=572

Global Entrepreneurs Monitor: 2004 Executive Report
[Online] at

[http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F90003968DB/\\$File/GEM+Global.pdf](http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F90003968DB/$File/GEM+Global.pdf)

Global Entrepreneurship Monitor (GEM). [Online] at [http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F90003968DB/\\$File/GEM+Global.pdf](http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F90003968DB/$File/GEM+Global.pdf).

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National Statistics Online
[Online] at <http://www.statistics.gov.uk/cci/article.asp?id=986> .

The Europa Enterprise and Industry arm of the European Commission [Online] at <http://europa.eu.int/comm/enterprise/entrepreneurship/craft/craft-women/women-dgentr-activities.htm>

US Centre for Women's Business Research
[Online] at <http://www.womensbusinessresearch.org/topfacts.html>

[Online] at <http://www.womensbusinessresearch.org/mediacenter/10-26-2005/10-26-2005.html>

Labour Source Survey. <http://laborsta.ilo.org/>

Prowess [Online] at

<http://www.prowess.org.uk/start/inspiration.asp>
http://www.prowess.org.uk/admin/library_new/130/Strategic%20Framework%20for%20Womens%20Enterprise.pdf

Small Business Survey [Online] at

http://www.prowess.org.uk/admin/library_new/130/Strategic%20Framework%20for%20Womens%20Enterprise.pdf

Everywoman.co.uk [Online] at <http://www.everywoman.co.uk>

[Online] at http://www.everywoman.co.uk/aboutus/WIBTheFacts_130803.doc

Household Survey of Entrepreneurship (2003) cited in (Acs et al. 2005). [Online at]: [http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F90003968DB/\\$File/GEM+Global.pdf](http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F90003968DB/$File/GEM+Global.pdf)

The Eurochambres Women's network *Women in Business and in Decision Making. A Survey on women entrepreneurs*(2004)

[Online]at

http://www.eurochambres.be/PDF/pdf_women_network/WiB%20Women%20final.pdf

Global Women Inventors and Innovators network <http://www.gwiin.com/>

Women's Entrepreneurship development

http://www.ilo.org/dyn/empent/empent.portal?p_lang=EN&p_prog=S&p_subprog=WE

United Nations Economic Commission for Europe Fact Sheet 4

http://www.unece.org/press/pr2004/04gen_n06e.htm

Organisation for Economic Co-Operation and Development

<http://thesius.sourceoecd.org/vl=7386389/cl=11/nw=1/rpsv/cgi-bin/fulltextew.pl?prpsv=/ij/oecdthemes/9998010x/v2001n19/s1/p11.idx>

National Statistics Online Growth in Self Employment

<http://www.statistics.gov.uk/cci/article.asp?id=986>

Appendix to Chapter 4.

Overview of the primary care contracting routes available to PCT's to commission or provide primary care medical services

The new General Medical Services (GMS), Personal Medical Services (PMS) and Primary Care PCT Led Medical Services (PCTMS) and Alternative Provider Medical Services (APMS) collectively are the four main UK contracting routes and provide a strategic framework to enable PCTs to plan, commission and develop high quality primary medical services. Through these routes, PCTs have considerable flexibility to develop services which offer greater patient choice, improved capacity and access, provide services for a specific population, and develop innovative approaches to service delivery enabling PCTs to commission medical services from a range of providers, including the independent sector, voluntary sector and not-for-profit organisations. These contracting arrangements are briefly summarised below.

- **General Medical Services (GMS)** is a practice-based contracting arrangement that rewards primary care health care professionals for designated outcomes achieved, rather than for the numbers of patients treated.
- **Personal Medical Services (PMS)** provide an alternative local arrangement to the national GMS and offers greater service provider flexibility.
- A newer model within the PMS framework introduced in 2004, is the **Specialist Medical Services (SPMS)**. This type of contracting arrangement is designed to enable providers other than the GP's to address needs not being fully met by other primary medical service options, thereby expanding capacity and reducing inequality particularly among disadvantaged or vulnerable groups. SPMS contractors are generally not expected to deliver the totality of essential primary medical services and contracts can only be

entered into by those qualified to hold PMS contracts thereby allowing staff to the retain NHS terms and conditions. Patients need not be registered with the provider to receive specialist care or core medical services. SPMS can be nurse-led or group of primary or secondary care clinical practitioners, a NHS Trust or GP providing specialist care to patients other than their registered patients.

- **Primary Care Trust-led Medical Services (PCTMS)** is a contracting arrangement that enables PCTs themselves, directly employing staff, under the PCTMS route. The PCT may wish to employ full time staff to provide a full range of services, or employ staff on a sessional or part time basis.
- **Alternative Provider Medical Services (APMS)** is a flexible contracting route introduced in April 2004, that gives PCTs powers to contract for services from a range of providers, for a range of primary medical services and runs alongside other primary medical care contracting routes.

Further information of NHS Primary care contracting is available as detailed below:

Principle website

DoH Primary Care Contracting website [http:// www.dh.gov.uk](http://www.dh.gov.uk)

GMS/PMS

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/fs/en>

APMS

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/APMS/fs/en>

SPMS

http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PMS/PMSArticle/fs/en?CONTENT_ID=4125644&chk=1YPbQD

Table 4.1. Intrapreneurs: Employees Acting in intrapreneurial and social intrapreneurial ways -Quasi-autonomous roles

Table 1a) Intrapreneurs acting in Quasi autonomous roles							
Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/inhibitors
1.	Smy J. 2006 Clients Respect and Appreciate Us. <i>Nursing Times</i> 102:20-1.* Journalist feature article	Specialist community nurses and Senior tenant housing support liaison	<ul style="list-style-type: none"> • A weekly drop in centre • Started 1994 	Preston, Lancashire	Lancashire NHS Care Trust and Nurse led funding campaigns	<ul style="list-style-type: none"> • Improve health needs of marginalized peoples- • Focus on single homeless • To expand current service and provide longer operating times 	<ul style="list-style-type: none"> • No permanent base move 3 times • Financial resources
2.	Daniel, K .1998 Working in partnership <i>Community Practitioner</i> 72; 5:117-118* Journalist Feature Article Daniel, K. 1999	<i>MD team of Community health worker, HV and colleagues</i>	<ul style="list-style-type: none"> • The Ore Valley Community project one of series of initiatives, part of a new primary care infrastructure, enhanced by use of a '1066 housing association' rent free flat (no. 147) for 1 year. This activity used a multi agency approach to problem 	Hastings, East Sussex	Initial funding (£4,500) provided through QNI innovation award scheme	<ul style="list-style-type: none"> • Tackle health inequalities and meet the disenfranchised, neglected and socially excluded health and social needs of women and older persons of 3 council estates identified in East Sussex Health report in 1995 • Professional aspirations include satisfaction and professional development 	<ul style="list-style-type: none"> • Difficulties of consensus between HC managers making decisions and the need for client consultation

Table 1a) Intrapreneurs acting in Quasi autonomous roles

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ inhibitors
	Banking on Success <i>Community Practitioner</i> 72; 12: 390 * News item		solving that included the residents of three deprived, council housing estates • Started 1998				
3.	Young, L 2001 Nurse-led teleconsultation service improves services for older patients. <i>Primary Health Care</i> 11;4:6* News item Macduff C. West B. Harvey S. 2001. Telemedicine in rural care. Part 2: Assessing the wider issues. <i>Nursing</i>	<i>District nurse/ Health visitor team</i>	<ul style="list-style-type: none"> • Pioneering nurse-led teleconsultation service for older persons in rural communities combining screening and assessment and if needed next day video link GP consultation • Study commenced and evaluated in 1999 	Hamlet, Angus region NE Scotland	Tayside Primary Health Care Trust	<ul style="list-style-type: none"> • Limitations of health care due to no medical practice or pharmacy services in the village • Optimism and opportunity to increase nurse role and scope of professional practice • A major patient benefit was not having to travel 6 miles to nearest GP surgery (pt choice/ easing access to care) • Reduced demands for GP's to village based • Ongoing difficulties faced by patients from foot and mouth outbreak • Strength of system was nurses role as an intermediary helping patients and doctors to understand 	<ul style="list-style-type: none"> • Doubt by GP's that tele - consultation of effectiveness compared to face to face consults • Scepticism that teleconsults are a cost measure offering low cost non-doctor branch surgery

Table 1a) Intrapreneurs acting in Quasi autonomous roles

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ inhibitors
	<p><i>Standard 15(33):33-7,2-8*</i></p> <p>Research</p> <p>Macduff C. West B. Harvey S. 2001. Telemedicine in rural care. Part 1: Developing and evaluating a nurse-led initiative. <i>Nursing Standard 15(32):33-8</i>, Apr 25-May 1*</p> <p>Research</p>					<p>different aspects of consults</p> <ul style="list-style-type: none"> Improved Dr/nurse communication mutual learning and understanding 	
4.	Walker, M Levett, K. 2002 Community nursing	Community Nurses	<ul style="list-style-type: none"> Collaborative pilot project with Age Concern to provide 	Northiam, Kent/Sussex	Not stated	<ul style="list-style-type: none"> Provide a rural area, proactive approach to practice in response to older 	Not stated

Table 1a) Intrapreneurs acting in Quasi autonomous roles

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ inhibitors
	Innovation. <i>Journal of Community Nursing</i> 16: 6 4-6 (DS) Practitioner narrative		advice, illness prevention and referrals to other services such as chiropodist, house sitters, telephone alert systems. • started April 2000 for period of 30 weeks	border-		people being reluctant to 'trouble ' the doctor • CN's aim was to prevent problems Improve communication, patient care and health care information for older people. • Expand nurse role	
5.	Lane D. 2001 Setting up a sexual health clinic in a school. <i>Nursing Times</i> 97(41). 11-10-2001.October* Practitioner narrative	School Nurse	• Collaborative Pilot service linking school - based sex education with appropriate social services based in the grounds of a school providing weekly sexual health clinic for youngsters • Started in 2001	Sheffield	Not stated	• Reduce rate of unplanned teenage pregnancies and sexual sexually transmitted diseases. • Improve access and availability of services- within school environment in an area of social deprivation	• Controversy about provision of contraception and sex advice in school surroundings. • Prescribing of emergency contraception
6.	Howard, H. 2003 Asylum seekers and primary care <i>Primary health Care</i> 13: 4;14-15* Journalist feature article	<i>Specialist Nurse Practitioner and HV team</i>	• MD homeless peoples, refugees and asylum seekers health care and training service that has developed resources and a client checklist for GP's, client held records and nurse led assessment for newly arrived asylum seekers	Croydon, Surrey	Not stated	• Expanding role for practice nurses • Need for lateral thinking and innovative partnerships • Run client focussed services balancing needs and rights • March 2003 the team won a QNI innovation and creative practice award for excellence in care of refugee and asylum seekers	Not stated

Table 1a) Intrapreneurs acting in Quasi autonomous roles

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ inhibitors
7.	Pfeil, M. Howe, A 2004 Health care for hard to reach groups. <i>Primary health Care</i> 14;7:23-26* Opinion piece	Collaborative Health Visitor initiative and PMS service partnership	<ul style="list-style-type: none"> Started March 2001 City Reach health Services providing PC service for all hard to reach groups eg. traveller's asylum seekers, refugees and female sex workers Started May 2002 	Norwich, Norfolk	Norwich Primary Care Trust- Initially staff employed on part time contracts remainder in mainstream NHS	<ul style="list-style-type: none"> Provide a highly flexible efficient service for vulnerable groups Accessible, weekly services in eg. homeless shelters, women's refuge travellers sites and a specifically designed mobile unit. Dual nature of roles prevents burn out and allows staff to widen expertises Multidisciplinary working No separation between medical and nursing agendas prevents burn out and allows staff to widen expertise 	Not stated
8.	Wild S. 2005 Innovative Practice – Actively managing obesity <i>Independent Nurse</i> 20.07.2005* http://www.independentnurse.co.uk/ Journalist feature article	Health Visitor	<ul style="list-style-type: none"> A lifestyle clinic for weight management, 3 days p.w. 6 sessions a week average of 15-20 patients per day, 16 times per year. Started January 2003 	New Southgate, West Yorkshire	<ul style="list-style-type: none"> Wakefield PCT initially 2 years funding for project from PCT topped up by modernisation funds At the end of project funding reduced to 2 sessions per week 	<ul style="list-style-type: none"> Provide a new lifestyle initiative and weight management programme Developing public health role for HV's. Develop direct GP referrals Provide a dedicated level of support Develop a workshop training scheme for others including expert patients 	Not stated

Table 1a) Intrapreneurs acting in Quasi autonomous roles

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/inhibitors
9.	Editorial journal article. 2003 Nurse led drop in centre to help asylum seekers. <i>Primary Health Care</i> 13;3;7* Journalist Feature Article	<i>Specialist Primary care nurse</i>	<ul style="list-style-type: none"> • New service for asylum seekers • Started April 2003 	Leicester	Eastern Leicester Primary Care Trust	<ul style="list-style-type: none"> • Help asylum seekers receive same level of care as any other member of the community • Provide range of information and advise on everything from language courses, paying bills, to immunisation 	<ul style="list-style-type: none"> • Hostility from sections of the public
10.	Healy P. 1998. Sure Thing <i>Health Service Journal</i> 13 August;12-13* Practitioner narrative	Health Visitors and Community workers	<ul style="list-style-type: none"> • A model for a pre-school, <i>Sure Start</i> project • Start date not stated 	Birmingham, the Midlands	<ul style="list-style-type: none"> • Sure Start is a national £540m initiative over 3 years. • Additional monies levered in e.g Midlands Police Authority 	<ul style="list-style-type: none"> • Improve lives of poor families and socially disadvantaged pre-school children • Health gain in areas such as depressive illness, • Achieve health gain in areas such as; depressive illness • Tackle infant mortality and morbidity 	Not stated
11.	Newcombe T, Gledstone P. 2003 Implementing Group work in primary care to meet client need	Health Visitors	<ul style="list-style-type: none"> • A family centred, public health approach among disadvantaged groups • Start date not stated 	Hertsmere, SW Hertfordshire	Not stated	<ul style="list-style-type: none"> • Tackle social and health inequality and improve health • Meet local community needs • Offer family centred public health approach • Provide cost and time effective approach through group work 	<ul style="list-style-type: none"> • Securing finance, • Staff recruitment • Accessing and recruiting group members • Arranging suitable meeting times

Table 1a) Intrapreneurs acting in Quasi autonomous roles

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ inhibitors
	<i>Nursing Times</i> 99; 27:30-2. *					<ul style="list-style-type: none"> MD teamwork offers wider perspective on situation, facilitates enhanced services. 	
	Practitioner narrative						
12.	The Walsall experience: a Summary. *	Health Visitors	<ul style="list-style-type: none"> A 12 month project 'Baby think it over' providing education to young people about responsibility of parenting targeting the high numbers of under age girls and boys who get pregnant Start date not stated 	Walsall, West Midlands	<ul style="list-style-type: none"> Funded Partnership between Walsall Community Health Trust and Walsall LA. Health visitors raised monies from Single Regeneration Budget (SRB4) 	Not stated	Not stated
	Project leaflet						
	News Item						
13.	Wrobel, B. 2002 <i>Clinic at Home- a service for housebound patients with diabetes</i> <i>Journal of Community Nursing</i> 16(1), 4-6. *	District Nurses	<ul style="list-style-type: none"> Mobile health service to annually review elderly, housebound diabetic patients Start date not stated 	Barking and Havering, Essex	PCG Brentwood Community Healthcare Trust	<ul style="list-style-type: none"> Address unmet patient needs Improve quality of care among vulnerable groups Housebound Diabetic patients 	Not stated
	Practitioner narrative						

Table 1a) Intrapreneurs acting in Quasi autonomous roles

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/inhibitors
14.	Smy J 2004 Bringing Health to the Homeless. <i>Nursing Times</i> . 100;4: 226-27* Journalist feature article	Health visitor	<ul style="list-style-type: none"> • Collaborative service with local GP practice/voluntary sector providing care and support for homeless people in 6 hostels and B& B's • Start date not stated 	Camden, North London	Camden PCT - PMS funding	<ul style="list-style-type: none"> • Rewarding and exciting role • Chance to be part of innovative solutions to problems • Variety and challenge 	Not stated
15.	Sandiford R. 2005 Caring without Prejudice. <i>Nursing Times</i> 101:12: 26-27* Journalist feature article	Health visitor	<ul style="list-style-type: none"> • A service development promoting awareness of travellers' healthcare needs. • Start date not stated 	St Albans and Harpenden, Herts	<ul style="list-style-type: none"> • 3 year post PCT funded initially 2 days per week • Currently post extended to 5 days per week 	<ul style="list-style-type: none"> • Challenge and rewards of working with a small but disadvantaged population group. • To empower and support travellers' to better self care and access to HC 	Not stated
16.	Rogers, R. 2000 Looking after the carers <i>Primary health Care</i> 10;2:8-10* Practitioner narrative	<i>District nursing team</i>	<ul style="list-style-type: none"> • Practice based service unique to carers providing informal opportunity for carers to discuss health and social needs • Start date not stated 	Belfast, N Ireland	South and East Belfast Health and Social Services Trust	<ul style="list-style-type: none"> • Acknowledgement of carers social and health need • Support carers mental social and physical wellbeing • Make a difference to carers lives 	Not stated
17.	Daniel, K. 2001	Health	<ul style="list-style-type: none"> • Unique service effecting behavioural 	Huddersfield	Huddersfield	<ul style="list-style-type: none"> • Establish methods of identifying Asian men at 	Not stated

Table 1a) Intrapreneurs acting in Quasi autonomous roles							
Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ inhibitors
	Najam breaks new ground <i>Community Practitioner</i> 74;7:256-255* Journalist Feature Article	Visitor <i>Quasi</i>	change among Asian men from a Pakistani community men's healthcare • Started not stated	, West Yorkshire	Primary Care Group	increased risk of CHD • Develop culture- sensitive health programme • Establish well man group • Extend conventional approach to Health Visiting • Target specific vulnerable groups • Bringing own cultural knowledge, sensitivity understanding	

[NB] There are many more examples of quasi autonomous Nurse and Health Visitor initiatives. For example over the past decade The Community Practitioner Journal has published articles describing at least 1-2 innovative activities per year. This equates to approximately 240 additional examples NHS employees acting in intrapreneurial and social intrapreneurial ways.

Table 1b. Intrapreneurs: Employees Acting in intrapreneurial and social intrapreneurial ways - CNS led redesigned services

Table 1b) Intrapreneurs- CNS service redesign							
Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
1.	Editorial. 1998. Awards help advance pioneering work in the community <i>Community Practitioner</i> 71;3:82* Brief News Item	Practice nurse -Winner of 1997 QNI Scholarship Awards	<ul style="list-style-type: none"> • A nurse-led anticoagulant clinic initiative. • Start date not stated 	Bitley, County Durham	Employed by GP's supplemented by award monies (QNI £2000, and £8000 by the NHS Executive)	<ul style="list-style-type: none"> • To treat patients at risk of stroke of heart disease locally rather than going to local hospital 	Not stated
2.	Davis C. 2005 Innovative Practice- Solving behavioural problems. <i>Independent Nurse</i> 25.07* http://www.independentnurse.co.uk	School Nurse -Winner of Primary Care Nursing Enterprise award 2005	<ul style="list-style-type: none"> • Unique new service in UK providing Children's mental health care across 4 primary schools. through effective solutions to behavioural problems in children by primary care nurse. • Started October 	Stockport, Cheshire.	Stockport PCT, Initially PMS growth money on temp basis now half funded by PCT	<ul style="list-style-type: none"> • Specialist work with children from 5 yrs excluded from school (issues of anger low self esteem, soiling self harm and ADHD). • Disappearance of CMH services • Strong liaison/ collaboration role with social services Youth Inclusion programme 	Not stated

Table 1b) Intrapreneurs- CNS service redesign

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	Journalist feature article		2003			and other agencies.	
3.	Bal R. 2004 Running the show. <i>Nursing Standard</i> ; 19:65*. Journalist Feature Article	Cardiac Nurse Specialists	<ul style="list-style-type: none"> • Nurse-led, out of hours, mobile life saving thrombolysis service delivered to local population • Start date not stated 	Fermanagh and South Tyrone N. Ireland.	Not stated	<ul style="list-style-type: none"> • To save a previous service from closure project- mobile coronary care unit otherwise have been withdrawn. • Reduction in junior Dr hours. • Added dimension to nursing • Made a reality of patient focussed care. • Serves local population • Personal satisfaction 	Not stated
4.	Crouch D. 2004 Spinal Cord Injury outreach <i>Nursing Times</i> ;100:29; 25-6* Journalist Feature Article	Spinal Cord Injury Specialist Nurses -Winners of NT National award 2004	<ul style="list-style-type: none"> • 1st UK Nurse-led spinal outreach service (hosp based but extends to monthly community clinics/ visits. • Start date not stated 	Middlesborough, Teeside	NHS funding	<ul style="list-style-type: none"> • Improve patient care • Professional job satisfaction • Continuity of care • Empowering patients 	Not stated

Table 1b) Intrapreneurs- CNS service redesign

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
5.	Hoban V. 2005 Managing Minor Illness. <i>Nursing Times</i> ; 101:20-2. * Journalist Feature Article	Primary Care Nurses	<ul style="list-style-type: none"> • Nurse-led services treating minor illnesses • Start date not stated 	Warrington, Cheshire Wokingham, Berkshire and Sussex	Warrington, Wokingham and Sussex PCT's	<ul style="list-style-type: none"> • Growing area of nursing • Reclaiming a first contact role • Opened up a career pathway Extended/ • Advanced nursing role 	<ul style="list-style-type: none"> • Professional opposition from medics • Pay equity • Prescribing restrictions • Referral difficulties
6.	Davis C. 2005 No Waiting in Vein. <i>Nursing Standard</i> ; 20:22-5.* Journalist Feature Article	Primary Care Nurses	<ul style="list-style-type: none"> • A collaborative primary and secondary care initiative resulting in the first PC nurse-led centre for specialized treatment of DVT created • Start date not stated 	Wirral, Merseyside	Bebington & West Wirral PCT, Birkenhead & Wallsey PCT and Wirral Hospital NHS Trust	<ul style="list-style-type: none"> • Reduce number of hospital admissions • Improve A & E waiting targets • Improve patient care • Flexible patient focused service • No reported nursing drivers 	Not stated
7.	Sands, J. 2006 Nurse-led clinics halves admissions. <i>Independent Nurse</i> 13	Cardiac Nurse Specialist working in primary care	<ul style="list-style-type: none"> • Nurse-led heart failure clinics run from community hospitals and local DGH • Start date not stated 	Essex	Colchester and Tendring PCT	<ul style="list-style-type: none"> • Asked to set up service • Reduce hospital admissions 	Not stated

Table 1b) Intrapreneurs- CNS service redesign

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	February, 7. * Brief News Item						

Table 2a) Nurse Consultancies in the UK - N and HV's providing their own expertise, knowledge and experience to public and private organisations

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/Inhibitors
1.	Payne C, et al 1997 Going it alone... entrepreneurial nurses. <i>Nursing Standard</i> 11:22-4. (DS) Practitioner narratives	Case study of Lesley Radley Independent Nurse Consultant	<ul style="list-style-type: none"> • Nurse consultancy • LMR is a Training and consultancy company offering a wide range of healthcare services • Works with husband on management issues • Acts as expert witness (particularly back injuries) • Started in 1989 	Monmouth, Gwent	<ul style="list-style-type: none"> • Financing not stated • Works with the NHS & independent health care settings, RCN, GP's and social services • Works with Public & Private sector 	<ul style="list-style-type: none"> • Variety, Interest • Exciting • Does some work with husband 	<ul style="list-style-type: none"> • Peaks and troughs of getting work • Time and effort to get it off the ground
2.	Cole A. 1997 Nurses who mean business. <i>Nursing Times</i> ; 93:38-9. (DS) Journalist Feature Article	Case study of Jenny Hilton Independent Nurse Practitioner	<ul style="list-style-type: none"> • Nurse consultancy • Provides range of services including, management consultancy, teaching, expert witness, air ambulance work, work on film sets and occasional leadership cover for local community hospital • Started in 1991 	Yeovil, Somerset	<ul style="list-style-type: none"> • Financing not stated • Works with Public & Private sector 	<ul style="list-style-type: none"> • Management reforms 1998 driver to leave an NHS management role, • Control of her own destiny • Personal satisfaction 	<ul style="list-style-type: none"> • Taking on too much work not setting limits • Longer hours • Fewer holidays

Table 2a) Nurse Consultancies in the UK - N and HV's providing their own expertise, knowledge and experience to public and private organisations

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
3.	Cole A. 1997 Nurses who mean business. <i>Nursing Times</i> ;93:38-9. (DS) Journalist Feature Article	Case study of Mary Rolt Independent Nurse Counsellor	<ul style="list-style-type: none"> • Nurse counsellor and CAB/Council mediator • Started in 1994 	Southend, Essex	Not stated	<ul style="list-style-type: none"> • Chance of early retirement from NHS • Independence • Personal satisfaction • Professional satisfaction 	<ul style="list-style-type: none"> • self employment • no sickness benefit holiday pay • securing a clientele • no set income
4.	Payne C, et al 1997 Going it alone... entrepreneurial nurses. <i>Nursing Standard</i> 11:22-4. (DS) Practitioner narratives	Case study of Valerie Smith	<ul style="list-style-type: none"> • Independent Management Consultant- VMS Associates, • Provides professional leadership , complex re-provision programmes for people with learning disability, development of commissioning strategy, legal expert witness, clinical risk management • Started in 1994 	Redhill, Surrey	Not stated	<ul style="list-style-type: none"> • Skills and expertises to undertake challenge • Broad range of assignments • Enhancement of professional work 	Not stated
5.	Payne C et al . 1997 Going it alone...	Case study of Annette Viant,	<ul style="list-style-type: none"> • Independent Nurse Consultancy - Safety Chain Specialist Nursing Consultancy • Provides services to NHS and 	Bradford on Avon, Bath	Not stated	<ul style="list-style-type: none"> • Flexibility, independence and expertise • 25 years of experience as infection control nurse 	<ul style="list-style-type: none"> • The need to market services effectively and build up clientele

Table 2a) Nurse Consultancies in the UK - N and HV's providing their own expertise, knowledge and experience to public and private organisations

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	entrepreneurial nurses. <i>Nursing Standard</i> 11:22-4. (DS) Practitioner narratives		independent organisations • Started in 1994			<ul style="list-style-type: none"> • Professional satisfaction • Working from home 	base
6.	Payne C et al . 1997 Going it alone... entrepreneurial nurses. <i>Nursing Standard</i> 11:22-4. (DS) Practitioner narratives	Case study of Christine Payne	<ul style="list-style-type: none"> • Independent Nurse consultancy- Coplestone Associates • Contracts with Public and Private sector • Started in 1997 	Rochester, Kent	<ul style="list-style-type: none"> • Income supplemented by nursing bank work, and short term contracts with NHS units private nursing homes and larger GP practices. • Not stated 	<ul style="list-style-type: none"> • 1991 health reforms • Challenge and opportunity to meet personal needs • Professional satisfaction • Variety of Short term contracts 	<ul style="list-style-type: none"> • Reduced regular income. • Uncertainty of work
7.	Smith V. 2003 Going solo. [Valerie Smith & Margaret	<ul style="list-style-type: none"> • Managing Partners of Bomar Services • Provides specialist advice and 	Wisbech Cambridge,	Not stated	<ul style="list-style-type: none"> • Belief in patients right to choose private or public sector health care 	Not stated

Table 2a) Nurse Consultancies in the UK - N and HV's providing their own expertise, knowledge and experience to public and private organisations

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<p><i>Nursing Management (Harrow) 10:8-9. (DS)</i></p> <p>Opinion Piece</p> <p>Website search www.bomar-services.co.uk</p>	<i>Moody</i>	<p>expertise in all areas of Care Home, and Home Care Management Main focus is to help owners improve performance and reduce operating costs through Improving Services and Quality</p> <ul style="list-style-type: none"> • Consultancy, advice, support and staff training, audits, verification, and assessment, complaints investigation and expert reports. • Started in 1997 			<ul style="list-style-type: none"> • Nurses right to choose where they work • Professional enhancement • Broad range of work opportunities 	
8.	<p>CPI Mediation Services Home Page*</p> <p>Website search www.cpims.com</p> <p>Practitioner Narrative</p>	<i>Denise Watling</i>	<ul style="list-style-type: none"> • Nurse Consultancy and Case Management • Works with various client groups • Developed an assessment model to quantify cost and rehab efficacy • Company website hosts a forum for case managers expert witnesses and solicitors • Started in 2002 	Southport, Lancashire	Not stated	Not stated	Not stated

Table 2a) Nurse Consultancies in the UK - N and HV's providing their own expertise, knowledge and experience to public and private organisations

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
9.	<p>Pollard, T 2004 Leg Club Innovative, inspirational practice <i>Br Comm Nursing</i> 9;9:364*</p> <p>Practitioner Narrative</p> <p>Website search www.legclub.org/ellie</p>	<i>Ellie Lindsay</i>	<ul style="list-style-type: none"> • Independent Specialist Nurse Practitioner and Clinical Consultant related to Leg Ulcer management • Launched • Developed new evidence-based model of care and the Lindsay leg club charity • Started in 2002 	Ipswich, Suffolk	Not stated	<ul style="list-style-type: none"> • Identified a need • Empowering patients with leg problems to participate in their care, in a social environment • Professional challenge • Personal satisfaction 	<ul style="list-style-type: none"> • Difficulty getting idea recognised • Difficulty setting up the Leg Club foundation • Hard work
10.	<p>Thompson N. 2005 Making Strides. <i>The Voice</i> (Britain's Best Black newspaper 25 Jul) *</p>	Norma Stride	<ul style="list-style-type: none"> • Nurse Consultancy and Training company -Prism Partnerships Consultancy • Provides teaching motivational and personal development skills to nurses and health workers • Started in 2002 	Not stated	Not stated	<ul style="list-style-type: none"> • Closure of college she was working at • New directions and opportunities and challenges • Family belief in a new generation of black entrepreneurs 	<ul style="list-style-type: none"> • Stiff competition long hours

Table 2a) Nurse Consultancies in the UK - N and HV's providing their own expertise, knowledge and experience to public and private organisations

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<p>Brief news item</p> <p>Website search www.voice-online.net/content.php?show=5860&yp_e*</p>						
11.	<p>Cole A. 1997 Nurses who mean business. <i>Nursing Times</i> 93:38-9. (DS)</p> <p>Journalist Feature Article</p>	<p>Case study of Roz Lloyd Davies</p>	<ul style="list-style-type: none"> • Personal Injury assessor • Start date not stated 	Not stated	Not stated	<ul style="list-style-type: none"> • Personal satisfaction • Fun 	<ul style="list-style-type: none"> • Getting paid on time by lawyers

Table 2a) Nurse Consultancies in the UK - N and HV's providing their own expertise, knowledge and experience to public and private organisations

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
12.	Hoban V. 2004 The nurse entrepreneurs. <i>Nursing Times</i> 100:20-2. (DS) Journalist Feature Article	Case study of Sonia Barzey,	<ul style="list-style-type: none"> Independent nurse trainer- Ocio Solutions Training Company for health professionals Start date not stated. 	Not stated	Not stated	<ul style="list-style-type: none"> Be own boss Not dictated to by government or organisation 	<ul style="list-style-type: none"> Financing everything
13.	Hoban V. 2004 The nurse entrepreneurs. <i>N. Times</i> 100:20-2. (DS) Journalist Feature Article	Simon Littlewood	<ul style="list-style-type: none"> Career advisor, training and personal coaching-Wentworth Ltd Start date not stated 	Not stated	Not stated	<ul style="list-style-type: none"> Strong self belief 	<ul style="list-style-type: none"> Overcoming idea that business won't work Success won't happen overnight
14.	Hoban V. 2004 The nurse entrepreneurs. <i>N. Times</i> 100:20-2.	Barbara Hastings-Asatourian	<ul style="list-style-type: none"> Managing Director - Contraception Education Ltd Provides sex education training and workshops Start date not stated 	Not stated	Not stated	<ul style="list-style-type: none"> Development idea Taking a risk Personal belief 	Not stated

Table 2a) Nurse Consultancies in the UK - N and HV's providing their own expertise, knowledge and experience to public and private organisations

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	(DS) Journalist feature Article Website search www.contraception.co.uk *						
15.	<i>Independent Nurse advertisement</i> 2005. 28 Nov. * Website search www.practitionersassocsoc.co.uk practitionersassociates@yahoo.co.uk	<i>Wendy Johnson & Helen Ward</i>	<ul style="list-style-type: none"> • Independent Nurse Consultancy - Practitioners Associates Ltd • Training company aimed at expanding NP's and other advanced practice health professionals who wish to enhance their knowledge base and skills in areas that challenge professional boundaries. • Provides workshops and master classes. • Start date not stated 	Orpington, Kent	Not stated	Not stated	Not stated

Table 2a) Nurse Consultancies in the UK - N and HV's providing their own expertise, knowledge and experience to public and private organisations

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<i>News Item</i>						
16.	Website search* http://www.pduk.net/ News Item	Debra Sharu	<ul style="list-style-type: none"> • Founder and Director of 1st nationwide company- Practitioner Development UK Ltd provides clinically focused, quality CPD for Advanced NP's through series of workshops master classes • Start date not stated 	Gosport, Hants	Not stated	Not stated	Not stated
17.	Editorial 2.005 <i>HSJ</i> Suppl Feb 24 * Journalist Feature Article	Katy Gordon, and Andy Ruckely	<ul style="list-style-type: none"> • Independent Nurse Consultancies in Leadership Training and Life skills coaching- <i>Co-creating Balance and Equilibrium Coaching</i> • Start date not stated 	Not stated	Not stated	Not stated	Not stated

Table 2. Entrepreneurs: Owners (and Employers) /self employed –Indirect healthcare services

Table 2b) Nurse entrepreneurs- workforce providers							
Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
1.	<p>Naish J. Stand up and stand out* accessed 24/05/2006 http://www.justfornurses.co.uk/career/careerpath/Standupandstandout.htm</p> <p>News Item</p> <p>Wallis, L 2003 Nursing Built My Career <i>N Standard</i> 20;3;70-71*</p> <p>Journalist Feature article</p>	Kate Bleasdale	<ul style="list-style-type: none"> • CEO Match Health Care Agency for nurse returners • Mergers with GP Deputising service to form Sinclair Montrose. Establishes Medicentres 1995. • 2001 ousted from board • 2003 wins £2.2 million compensation for sex discrimination • 2003 Starts Healthcare Locums • 2005 buys rival Recruitment Solutions Group • started in 1987 	Loughton	<ul style="list-style-type: none"> • Borrowed £10,000 from bank 	<ul style="list-style-type: none"> • Spotted gap in nursing recruitment market as more hospitals used agency nurses • Way to improve quality of patient care • Financial reward • Business driver • Nurses have transferable skills 	<ul style="list-style-type: none"> • Legal barriers • Sex discrimination • Finding continuing Financial backing
2.	Hoban V. 2004	Case study of	<ul style="list-style-type: none"> • Managing Director of 	Not stated	<ul style="list-style-type: none"> • HSBC loan based on 5 	<ul style="list-style-type: none"> • To make a difference 	<ul style="list-style-type: none"> • 24.7 service for first 2

Table 2b) Nurse entrepreneurs- workforce providers

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	The nurse entrepreneurs. <i>N. Times</i> ;100:20-2. (DS) Journalist Feature article	Michelle Patrick	<ul style="list-style-type: none"> • Healthcare Solutions • Nursing agency. • <i>12 branches, with 4,500 nurses and 71 office staff</i> • <i>Started in 1996</i> 		year business plan	<ul style="list-style-type: none"> • Opportunity (not stated) arose • Better lifestyle • Financial rewards 	years only 10 hours off per week <ul style="list-style-type: none"> • Difficulties when 2nd child came long

Table 2b) Nurse entrepreneurs- workforce providers

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
3.	<p>Website search http://www.chilversmccrea.co.uk* http://www.tribalgroup.co.uk/media_centre/article_detail.aspx?ID=234</p> <p>plus referenced by O'Dowd A. 2005 Primary Care Pioneers <i>N Time.</i>: 101: 39: 16-18 (DS)</p> <p>Chatterjee M. 2005 Nurses appreciate benefits of privately run GP practices. <i>N. Times</i>: 25 Jan 101: 4; 4*</p> <p>Allott, S 2006 Why we're Good with Numbers April . Sunday Mail *</p> <p>Journalist feature Articles</p>	<p><i>Sarah Chilvers and Rory McCrea</i></p>	<ul style="list-style-type: none"> • Managing Directors of ChilversMcCrea Health Care Vision. • Primary care management services. 20 practices run under PMS nGMS and APMS contracts • UK's first corporate NHS general practice • Direct clinical and management leads • Plus central finance, HR and payroll functions. • Staff employed by the company. • Started in 2001 	<p>Magdalen Laver, Essex</p>	<ul style="list-style-type: none"> • Recently announced the formation of a strategic alliance with Mercury Health, part of the Tribal Group PLC. • This strategic alliance brings together NHS on the ground "know how" and experience with large scale corporate muscle and finance, thus allowing • Start up costs Not stated 	<p>Not stated</p>	<p>Not stated</p>

Table 2b) Nurse entrepreneurs- workforce providers

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
4.	<p>Website search Naish J. Accessed 24/05/2006 Stand up and stand out http://www.justfornurses.co.uk/career/careerpath/Standupandout.htm*</p> <p>News Item</p> <p>Website search http://www.scotnursing.com/</p>	<p><i>Case study of Ann Rushworth</i></p>	<ul style="list-style-type: none"> • Founder of Scotnursing - Nursing agency providing staff and training. • Start date not stated 	<p>Old Kilpatrick, Glasgow</p>	<ul style="list-style-type: none"> • Initial financing not stated • Annual turnover of £10 million 	<ul style="list-style-type: none"> • Self belief women can develop own business 	<p>Not stated</p>

Table 2 Entrepreneurs: Owners (and Employers) /self employed- Indirect healthcare services

Table 2c) Inventors/manufacturers							
Ref No.	Reference	Nurse	The Activity (Date Ordered)	Financial arrangements	Geographic location	Reported Drivers	Reported Inhibitors
1.	Porokhnya M. 2005 Entrepreneur, sheep farmer midwife. <i>The Practising Midwife</i> 8:1:36-37 (DS) ltrdatacards@aol.com Journalist Feature Article	Lynette Roberts	<ul style="list-style-type: none"> Part time practising Midwife inventor of health care product 'small business selling ' Lots to Remember' Data cards for midwives - LTR Ltd employees 8 employees Now expanding to other nurse groups and other professionals such as army, police etc Launched August 2002 	<ul style="list-style-type: none"> Financing for printing from sale of half of husbands sheep. Product bought by individuals 	Ashford, Kent	<ul style="list-style-type: none"> Idea inspired from personal experience notes/essential clinical info/ aide memoires got ruined in wash! Clinical credibility as also working as MW and 'lamber'. Professional satisfaction 	<ul style="list-style-type: none"> Daunting running a business
2.	Hoban V. 2004 The nurse entrepreneurs. <i>N. Times</i> 100:20-2. (DS) Journalist Feature Article	John Edwards	<ul style="list-style-type: none"> Inventor of IV device to support IV fluids without needing full drip stand - 'Hook-It' Product rolled out form June 2004 	<ul style="list-style-type: none"> Financial backing from R & D Manager of NHS Trust. Product bought by NHS Purchasing and Supply Agency 	New Cross Hospital, Wolverhampton	<ul style="list-style-type: none"> Taking risk by developing idea Wanting ownership of idea Financial rewards 	Not stated
3.	Hill, M. 2005 Lets Hear it for the	Michael Hill	<ul style="list-style-type: none"> Inventor of medical device olive oil spray - Earol ® Launched 2005 	<ul style="list-style-type: none"> Bank loan from High Street bank matched personal funding 	Not stated	<ul style="list-style-type: none"> Challenge of sales and marketing an idea Change in career 	Not stated

Table 2c) Inventors/manufacturers

Ref No.	Reference	Nurse	The Activity (Date Ordered)	Financial arrangements	Geographic location	Reported Drivers	Reported Inhibitors
	Entrepreneur. <i>Primary Health Care</i> 15;5;20-21* Practitioner narrative			and funds from friends and family		direction • Nursing background	
4.	Hoban V. 2004 The nurse entrepreneurs. <i>N.Times</i> 100:20-2. (DS) Journalist Feature Article Website search http://www.contraception.co.uk Novarix Ltd The Nurse Entrepreneurs N Times July 2004 http://www.novarix.co.uk/pre ss1.htm	Barbara Hastings-Asatourian - Winner of British female inventor of year in 2003.	<ul style="list-style-type: none"> • Inventor of board game to teach sex education to young people with learning difficulties. • Managing Director of Contraception Education Ltd • Launch date not known 	Not stated	Glossop, Derbyshire	<ul style="list-style-type: none"> • Development of an idea into a business • Improve sex education for young people with learning difficulties 	Not stated

Table 2c) Inventors/manufacturers

Ref No.	Reference	Nurse	The Activity (Date Ordered)	Financial arrangements	Geographic location	Reported Drivers	Reported Inhibitors
5.	<p>Hoban V. 2004 The nurse entrepreneurs. <i>Nurs. Times</i> 100:20-2. (DS)</p> <p>Journalist Feature Article</p> <p>Website search http://www.medgadget.com/archives/2005/07/stabiline_n_o_mo.html July 13 2005*</p> <p>News Item</p>	<p>Lisa Kagenow</p>	<ul style="list-style-type: none"> ▪ Inventor of device to stop IV lines kinking- Uni-line/ Stabi line: No more Kinks ▪ Managing Director of Novarix Ltd that markets the product ▪ Launch date not known 	<p>Financing not stated</p>	<p>Not stated</p>	<ul style="list-style-type: none"> • Part of PHD research at Oxford University • Identified problem and found designed a solution • Desire to make nursing easier • Improve patient care 	<p>Not stated</p>

Table 3. Entrepreneurs: Owners (and Employers) /self employed – Providers of mainstream NHS health services through direct contract with NHS

Table 3a) Mainstream health services delivered through the NHS							
Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
1.	<p>Daniel, K. 2000 Moving On <i>Community Practitioner</i> 73 11:830-831*</p> <p>Journalist Feature Article</p> <p>Cohen, P 1998. <i>Breaking Down the barriers.</i> Community Practitioner 71;3:93*</p> <p>News item</p>	Mary Low & Celia Suppiah	<ul style="list-style-type: none"> • Thurrock 'Community Mothers programme' partnership working • Operates under PMS contract • Developed from PMS pilot in 1998 	Grays, Essex	<ul style="list-style-type: none"> • QNI funding enabled service to build on fragmented existing services 	<ul style="list-style-type: none"> • Tackle Health inequalities • Personal experience understanding and credibility amongst homeless and travellers • Advocate of the PMS initiative • Personal and professional job satisfaction • Multidisciplinary partnership working 	Not stated
2.	<p>Payne D. 1998. Working upto a new partnership in an old practice. <i>N Times</i>; 94 (1) *</p> <p>Journalist feature article</p> <p>DoH Press release. 23 Dec 1997*</p>	Lesley Hargreaves	<ul style="list-style-type: none"> • Nurse clinician successfully bid to run a single GP practice list in partnership with GP. • Started in 1998 	Ormskirk, South Lancashire	Independent contractors to NHS	<ul style="list-style-type: none"> • To develop a nurse led system of primary care extending nursing role to focus on improving health promotion, CDM referrals to secondary care. • Extended role as Nurse clinician. 	<ul style="list-style-type: none"> • Patients fear of a two -tier system of health.

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<p>News Item</p> <p>Crawford M. 1998. Nurses lead the way. <i>Practice Nurse</i>:15:3:127-128*</p> <p>Journalist feature article</p> <p>Cohen, P 1998. <i>Breaking Down the barriers.</i> <i>Community Practitioner</i> 71;3:93</p> <p>Opinion piece</p>						
3.	<p>Bunce C. 2002 Brave New World. <i>N. Times</i> 98:24-5.*</p> <p>Journalist feature article</p> <p>Editorial 2005 Primary Care Contracting- How to set and run your own practice <i>Independent Nurse</i> 24.01. *</p> <p>Journalist feature article</p>	<p>Catherine Baraniak</p> <p>-Received an OBE for services to primary care 2003</p>	<ul style="list-style-type: none"> • Independent nurse contractor operating new single- handed Nurse-led primary care practice. • Part of the 1st wave nurse-led pilot PMS employing 25 staff including 2 GP's. • Nurses perform the majority (65%) of consultations. GP remains clinically responsible for the list. • Operates under 'PMS Only' contract 	Derby, Derbyshire	Self employed	<ul style="list-style-type: none"> • Shift in powerbase from GP's to wider team patients to see most appropriate provider • Patients involved in service design • Benefits of self employment, include better pay and greater job satisfaction 	<ul style="list-style-type: none"> • See Kings Fund report findings • PMS contractors can be isolating no safety net for nurses • Doubt that nurse led PMS would work in mainstream population

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<p>www.independentnurse.co.uk/professional/index.cfm?fuseaction=ArticleView&</p> <p>Crawford M. 1998. Nurses Lead the Way. <i>Practice Nurse</i> 15:3:127-128*</p> <p>News item</p> <p>Baraniak, C. 2001 A Normal Community. <i>Primary Health Care</i> .11;2:14-15*</p> <p>Practitioner narrative</p> <p>Sylvester, J. 2001. A pioneering role for nurses. <i>Primary Health Care</i> 11 3;5*</p> <p>News item</p> <p>Cohen, P 1998. <i>Breaking Down the Barriers. Community Practitioner</i></p>		<ul style="list-style-type: none"> Started in August 1998 				

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	71;3;93* Opinion Piece Lewis R. 2001 Kings Fund, <i>Nurse –Led Primary care: Learning from Pilot sites</i> . p12. Report analyses data gathered from 9 nurse led pilot sites through 2 focus groups* Kings Fund Report						
4.	Lewis R et al 2001 Kings Fund, <i>Nurse –Led Primary care: Learning from 9 nurse led Pilot sites</i> . p12. * Report analyses data gathered through 2 focus groups Kings Fund Report	Theresa Kerney & Mary Low	<ul style="list-style-type: none"> • Nurse practitioner and Health Visitor operating a PMS nurse-led pilot for travellers and homeless families and outreach services • Operates under 'PMS Plus' contract; plus includes midwifery and child development. • Started in October 1998 	Grays, Essex	Contracted to South Essex Mental Health and Community Trust	<ul style="list-style-type: none"> • Target vulnerable patient groups • Redesign services to become more patient focused • Maximise nurse and Dr Competencies. 	<p>Also see Kings Fund report findings</p> <ul style="list-style-type: none"> • Struggle of implementing pilot site • New model of service • Insufficient flexibility • Regulatory obstacles • Primary secondary care inter-professional tension/recognition /equality/cooperation

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<p>Crawford M 1998. Nurses lead the way. <i>Practice Nurse</i> 15:3:127-128 (DS)</p> <p>News item</p>						<ul style="list-style-type: none"> • Referral acceptances • Pressure from being a pioneer/role model • Suspicion/scepticisms/and some hostility towards model of care
5.	<p>Chapple A. 2000 Two years' experience of a nurse –led pilot scheme: patients' perceptions. <i>Primary Health Care</i> 10:14-7 (DS) *</p> <p>Research</p> <p>* (cross ref to Table 3) a Research study that investigated patients perceptions of a nurse-led, personal medical service.</p> <p>Moore A. 2002 PMS mood swings. <i>HSJ</i> 112;5799: 12-14*</p>	Lance Gardner	<ul style="list-style-type: none"> • Independent nurse contractor- Part of the 1st wave of pilot PMS service schemes. • Nurse-led primary care service. LG took over a vacant single handed GP practice in • One of three projects in Manchester that aimed to develop a new arrangement involving the community in the work and governance of statutory agencies. • Adapted the 'school governor model' to create a governing body of patient's, city councillors PCG members and 2 PMS pilot staff members. • Operates under 'PMS Plus' 	Salford, Manchester	Independent contractor to Salford PCT NHS	<ul style="list-style-type: none"> • PMS described as the most radical initiative in primary care so far. • Success relates to commitment of skilled, experienced individuals. • Nurse-led PMS pilots represent a vanguard for new and extended roles for nurses in primary care. 	<p>Complicated admin and management issues such as:</p> <ul style="list-style-type: none"> • Certification- nurses cannot sign death or sick certificates and since Mental health act 1984 nurses cannot section patients. • Prescribing- Nurses restricted prescribing autonomy at the

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<p>Journalist feature article</p> <p>Gardener L. Nurse-led PCAPS. The plot thickens. <i>QNI Newsletter</i>, Autumn 1998. p4. *</p> <p>News item</p> <p>Lewis R. 2001.Kings Fund Nurse –Led Primary care: Learning from Pilot sites. p12. Report analyses data gathered from 9 nurse led pilot sites through 2 focus groups*</p> <p>Kings Fund Report</p> <p>Crawford M. 1998 Nurses lead the way. <i>Practice Nurse</i> 15:3:127-128*</p> <p>Journalist feature article</p> <p>Cohen, P. 1998. Breaking Down the barriers. <i>Community Practitioner</i> 71;3:93*</p> <p>Opinion Piece</p>		<p>service contract: Plus community nursing services.</p> <ul style="list-style-type: none"> Started in 1998/9 <p>NB This practice is no longer nurse led, (LG left in 2001 and practice merged with another local practice in Salford)</p>				<p>time of the pilot.</p> <ul style="list-style-type: none"> Grant allocation- NPact legislation did not allow health authorities to allocate improvement grants to nurses, services could be in substandard accommodation. <p>Premise that nurse led PMS are for the most vulnerable and needy deserving type of care best provided by nurses, but in reality relies of partnership between GP and nurses.</p>

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
6.	Lewis,R et al 2001 Kings Fund, Nurse –Led Primary care: Learning from Pilot sites. (DS) Report on research data	Summary evaluation of activities of 9 nurses at: • Acorns • Appleton primary care • Arch day centre • Daruzzuama n • Edith cavell • Meadowfield s • Morley Street • Spitalfields • Valley park	<ul style="list-style-type: none"> • 1st nurse led PMS activities, 5 managed by community NHS trusts, 2 managed by existing GP practices and 2 managed by nurses • Started in April 1998 – Dec 1999 	UK wide	NHS Trust	<ul style="list-style-type: none"> ▪ To maximise nursing skills ▪ Allow nurse leadership within PHC team ▪ Break down professional boundaries between medical and nursing roles ▪ Provide new model of care nurses ▪ Improve access to services ▪ Empower patients ▪ Develop partnerships with other agencies and community groups 	<ul style="list-style-type: none"> • Struggle of implementing pilot site • New model of service • Insufficient flexibility • Welfare and NHS Regulatory obstacles • Restricted prescribing facility • Primary secondary care interprofessional tension/ recognition/ equality/cooperation • Referral acceptances • Pressure from being a pioneer/role model • Suspicion /scepticism/ and some hostility towards model of care particularly to mainstream rather disadvantaged population • Limited support from professional

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
							bodies
7.	<p>O'Dowd A. 2005 Primary Care Pioneers <i>N Times</i> 101: 39: 16-18 (DS)</p> <p>Journalist feature article</p> <p>Lewis, R et al Kings Fund, Nurse –Led Primary care: Learning from Pilot sites. 2001 p12. Report analyses data gathered through 2 focus groups*</p> <p>Kings Fund Report</p> <p><i>Sands, J. 2006 Advice for nurses setting up services Independent nurse</i> 13 March*</p>	Kate Cernik	<ul style="list-style-type: none"> • Lead nurse and Senior Partner in 3-way Partnership of lead nurse, practice manager and GP. • Part of the 1st wave nurse-led pilot PMS in new practice in affluent part of Warrington <p>Operates under 'PMS Plus' contract: Plus community nursing services</p> <ul style="list-style-type: none"> • Started in August 1999 <p>[NB] has also set up a small training company with a GP to present series of workshops for</p>	Warrington, Cheshire	Independent contractor to NHS	<ul style="list-style-type: none"> • To offer holistic patient focussed services. • Develop primary care opportunities for NE's increasing scope for nurse partners breaking down professional boundaries. • Offer good 'value' 	<p>Also See Kings Fund report findings.</p> <ul style="list-style-type: none"> • Confidence • Communication with GP's.

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	Brief news item		nurse interested in contracting opportunities				
8.	Godfrey, K 2006 Nurse led Triage in General Practice <i>N. Times</i> 102;13: 42-43* Journalist feature article	Nurse Partner	<ul style="list-style-type: none"> • Nurse led triage system nurse led disease specific and minor illness clinic • Nurse is a full partner, has partner's vote caseload own practice room and parking space • Started in 2000 	Doncaster,	<ul style="list-style-type: none"> • Self employed receives percentage of the practice partnership • Independent contractor to NHS 	<ul style="list-style-type: none"> • Difficulty in recruitment of GP enabled nurse to become a partner 	<ul style="list-style-type: none"> • Professional tensions and jealousies • Some distrust locally of nurse prescribing
9.	Wright C 2004. Breaking down the barriers. <i>Community Practitioner</i> , 77: 7: 242-244* Journalist feature article	Jane Macpherson	<ul style="list-style-type: none"> • Nurse-led GP practice in which a Full Practice partner of 4.5 WTE GP's and 1WTE Nurse partner managing total of 12 FT staff including 4 RGNs and 1 nursing assistant • Operating under a nGMS contract • Started in Jan 2001 	Lanarkshire Scotland	Independent contractor to NHS	<ul style="list-style-type: none"> • Start of fundholding which prompted expanding role beyond clinical activities and <ul style="list-style-type: none"> ▪ Move into strategic and managerial functions. ▪ Changing cultures ▪ Clinical patient focussed nurse-led approach. 	Not stated

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
10.	Houghton M. 2002; We bought our own GP. <i>N. Times</i> , 98:28-9. (DS) Journalist feature article	<i>Joanne Davidson & Julie Burford & Yvette Townsend</i>	<ul style="list-style-type: none"> • Pioneering Primary Health Care Practice 1st nurse led PMS pilot scheme in W Midlands. • Operates under a 3-way Equal Partnership employs the GP whose practice has been bought (GP has since retired and has not been replaced yet because of area) and 12 people. • The practice houses CAB, alcohol advisory services counselling services, access to internet health information GP and NP services. • Operates under PMS contract • Went live on 1st April 2001. 	Tipton, West Midlands	£250,000 raised from bank to buy GP practice. Operate as Independent contractors to NHS	<ul style="list-style-type: none"> • Opens up new career structure • Allows creative ideas to meet local need. • 'Nurse-led culture' better for patient care, • More time & continuity of care. • Provides new services within same resources. • Teamwork success • Being an entrepreneur and risk taker • Confidence, • Persistence. 	<ul style="list-style-type: none"> • Legislation: Currently no parity with Drs over prescribing. • Attracting GP to work in the practice.
11.	O'Dowd A. 2005 Primary Care Pioneers <i>N. Times</i> 101: 39: 16-18(DS) Journalist feature article Dinsdale P. 2005;	Delia Clarke	<ul style="list-style-type: none"> • Nurse Partner in 2 way partnership with Practice manager • Operates under PMS contract • Started in 2002 	Leigh, Lancashire	Independent contractor to NHS	<ul style="list-style-type: none"> • Pay not seen as always a priority emphasis on quality of care, • Greater job satisfaction, • Poor GP recruitment provides opportunity for professional career development. 	<ul style="list-style-type: none"> • Challenge to status quo for Nurses and Drs. • There is still lack understanding of about PCT's in relation to pension (non -GP providers in GMS and PMS eligible for NHS pensions) • Indemnity insurance

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<p>Taking the lead. <i>Nursing Standard</i> 19:12-3. *</p> <p>Journalist feature article</p> <p>*Report of findings from the National Primary Care Trust Development Programme conference in Leeds(2005) part of the Modernization Agency).</p>						not available through RCN need to get from a medical protection association.
12.	<p>Bension L. 2005 Anne Hamerton: running the practice. <i>Practice Nursing</i> 16:362. (DS)</p> <p>Journalist feature article</p> <p>Wild S,A. 2005. Nurse-led practice in West London. <i>Independent</i></p>	<p><i>Anne Hamerton & Carol Sears</i></p>	<ul style="list-style-type: none"> • 3 -way equal lead, Partnership practice with 2 PN's, 2 NP's and 3 GP's. • Operates under APMS contract • Started in April 2005 	Hanwell, West London	<ul style="list-style-type: none"> • Investment by ECT Group a local social enterprise group • Not –for profit enterprise • Independent contractors to NHS 	<ul style="list-style-type: none"> • Challenge to run own practice. • Opportunity for nurse led development • Pts registered with practice not GP. • GP's now have longer appt times. • NP's manage long-term conditions and same day appointments. 	Not stated

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<p><i>Nurse 31.10. *</i></p> <p>Journalist feature article</p> <p>Editorial 2006 Peer profile: Carol Sears <i>Independent nurse</i> 20 February*</p> <p>Journalist feature article</p>						
13.	<p>O'Dowd A. 2005 Primary Care Pioneers <i>N Times</i> 101: 39: 16-18 (DS)</p> <p>Journalist feature article</p>	Helen Ramsey	<ul style="list-style-type: none"> • The only full and equal nurse partner of 7 partners • Operates under nGMS contract • Started April 2005 	Gateshead.	Independent contractor to NHS	<ul style="list-style-type: none"> • Partnership gives official role involved in decision making • Permits voting rights on the board 	<ul style="list-style-type: none"> • Challenge to status quo from Nurses and Drs. • PCT's still lack understanding of pension (non GP provide'rs in GMS and PMS eligible for NHS pensions) issues and insurance. • Indemnity insurance not available through RCN only through a medical protection

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
							association.
14.	Crumbie, A. 2006 Nurse Partnership for Nurse Practitioner. <i>Primary Health Care</i> 16;4: 14-16.* Personal Narrative	Alison Crumbie	<ul style="list-style-type: none"> • Profit sharing partner • Operates under a nGMS contract • Started April 2005 	Windemere, Cumbria	Independent contractor to NHS	<ul style="list-style-type: none"> • New responsibilities • Professional challenge and excitement • Personal and financial commitment 	<ul style="list-style-type: none"> • Greater level of liability • Indemnity insurance from RCN
15.	Pritchard J. 2005 Providing nursing services under a SPMS contract. <i>Independent Nurse</i> ; October 3:6-7*. Opinion piece Editorial. 2005 Nurses win contract to	<i>Jo Pritchard & Tricia Mc Gregor</i>	<ul style="list-style-type: none"> • Primary Care Directors of nurse-led limited company 'Central Surrey Healthcare' providing community and school nursing and therapy services • Approval granted April 2006 • Will operate under SPMS contract 	East Elmbridge and Mid Surrey PCT	<ul style="list-style-type: none"> • Limited company • Not for profit • £27 million contract agreed by PCT • Each employee will have one share in the company retaining NHS 	<ul style="list-style-type: none"> • Anticipated benefits: • Organisational stability, culture shift and responsiveness • SPMS contract is seen as future proof and flexible. • Gives control over how and who delivers services 	Not stated

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	<p>provide services <i>Independent Nurse</i> 21nov:p3*</p> <p>Brief news item</p> <p>Editorial. 2005 Nurse-Owned Company Wins PCT Contracts <i>Nursing Standard</i> Nov 23; 20;11: p9*</p> <p>Brief news item</p> <p>Bower,E. 2006 Social Enterprises need support right now. <i>Independent Nurse</i> 20 February;11*</p> <p>Brief news item</p> <p>Cavel, J. 2006. <i>Inner Visions.</i> The Guardian 25/01</p> <p>Brief news item</p>				<p>conditions of work, including NHS pension</p> <ul style="list-style-type: none"> • Independent contractor to NHS 	<ul style="list-style-type: none"> • Allows NP's to think innovatively. • Ties in with government aims for PCTs to commission services from outside contractors rather than providing services themselves 	

Table 3a) Mainstream health services delivered through the NHS

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
16.	<p>O'Dowd A. 2005 Primary Care Pioneers <i>N. Times</i> 101: 39: 16-18*</p> <p>Journalist feature article</p> <p>Communication and presentations obtained from original www.natpact.nhs.uk (nb. NatPact program closed on 31 Mar 2005) *</p> <p>Practitioner narratives</p>	Linda Aldous	<ul style="list-style-type: none"> • Joined as practice nurse partner in 1999 under old GMS contract now Practice Nurse Partner one of 8 , 5 GP partners, Nurse partner, manager partner and honorary partner • Employs staff of 27 • Operates under a PMS contract • Start date not stated 	Bromley by Bow, East London	Self-employed, contracting to local PCT	<ul style="list-style-type: none"> • Team work, negotiation skills, • Energy and vision • Voice for nurses through decision making process • Patient advocacy 	Not stated

Table 3. Entrepreneurs: Owners (and Employers) /self employed Direct patient healthcare

Table 3b) N, M, HV services offered directly to clients							
Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
1.	Cole A. 1997 Nurses who Mean Business. <i>Nursing Times</i> 93:38-9. (DS) Journalist feature article	Mary Rolt Registered Nurse	<ul style="list-style-type: none"> • Independent Counsellor • Undertakes a range of jobs counselling, consultancy, teaching, CAB work and mediator for local council. • Started in 1994 	Not stated	Not stated	<ul style="list-style-type: none"> • Opportunity for early retirement • Greater independence 	Not stated
2.	Munro R. 1999 The Battler of Hastings... Steve Clifford. Community Mental Health Nurse. <i>Nursing Times</i> Jan 27-Feb 4; 95:32-3. (DS) Journalist feature article	Steve Clifford Community Psychiatric Nurse	<ul style="list-style-type: none"> • Independent CPN practitioner working from a GP practice. • Also provides staff training, consultation, counselling and supervision. • Employs 1 part-time therapy assistant • Started in 1995 	Rye, East Sussex	Not stated	<ul style="list-style-type: none"> • Vision and faith • New opportunity • Ability to negotiate contracts • Job flexibility and immediacy of contact • Personal and Professional accountability • Autonomy • Fortnightly supervision maintenance of peer contact • Enhancing professional status 	<ul style="list-style-type: none"> • Being able to negotiate contracts • Becoming more flexible in your work • Daunting prospect of self employment
3.	Rigby M. 2000	Deborah Rigby	<ul style="list-style-type: none"> • Part time Independent • Continence Advisor 	Not stated	Not stated • Services bought by	Not stated	<ul style="list-style-type: none"> • Personal indemnity

Table 3b) N, M, HV services offered directly to clients

Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
	They are. Are you?... the pros and cons of being an independent practitioner. <i>Nursing Times</i> 20-26; 96:32-3. (DS) Journalist feature article	Registered Nurse	<ul style="list-style-type: none"> Started in 1997 		individuals		Insurance <ul style="list-style-type: none"> Erratic referrals, Overhead costs
4.	Rigby M. 2000 They are. Are you?... the pros and cons of being an independent practitioner. <i>Nursing Times</i> 20-26; 96:32-3. (DS) Journalist feature article	Mary Dolman Registered Nurse	<ul style="list-style-type: none"> Independent CNS providing Stoma & Continence Care Start date not stated 	Ascot, Berkshire	<ul style="list-style-type: none"> Services bought by individuals Financing not stated. 	<ul style="list-style-type: none"> Self belief in skills and clinical expertise Location of business 	Not stated

Table 3. Entrepreneurs: Owners (and Employers) /self employed- Direct patient healthcare

Table 3c) Other health related services provided by N,M,HV directly to a client							
Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
1.	<p>Andrews G. 2003</p> <p>Nurses who left the British NHS for private complementary medical practice: Why did they leave? Would they return?</p> <p><i>J Ad Nursing</i> 41;4 403-415 *</p> <p>Research</p>	63 nurses	<p>Providers of Complementary Therapies</p> <ul style="list-style-type: none"> • Date of any of the services started not stated 	Not stated	<ul style="list-style-type: none"> • Individual financing not stated • Funding direct from clients 	<ul style="list-style-type: none"> • 2nd career • Greater job satisfaction • Compulsion to help people • Financial rewards • Reasons for leaving NHS – disillusionment job dissatisfaction, lack of continuity, stress • Job to do as got older • To practice a holistic form of care • Belief in efficacy of CT • Gap in NHS service provision • Unhappy with modern medical practices • Personal job satisfaction 	<p>Negatives of self employment include;</p> <ul style="list-style-type: none"> • Lack of sickness/maternity pay • Irregular income • Reduced income • Professional isolation • Lack of business acumen • Business related stress factors

Table 3. Entrepreneurs: Owners (and Employers) /self employed –Direct patient healthcare

Table 3d) Other health related services and accommodation by nurses proprietors							
Ref No.	Reference	Nurse	The Activity (Date ordered)	Geographic location	Financial arrangements	Reported drivers	Reported barriers/ Inhibitors
1.	Website search* www.positivelifestyles.co.uk <i>News item</i>	Jane Taylor	<ul style="list-style-type: none"> • Managing Director - Positive Lifestyles Health Ltd • Local initiative providing specialist residential support for behaviourally challenged young adults with learning disabilities, behavioural and mental health concerns • Company employs 24 staff • Started in 2001 	West Cardiff, Wales	<ul style="list-style-type: none"> • <i>Start up costs not stated.</i> • Independent provider, services bought by Public Social and Health care sectors 	Not stated	Not stated

Appendix 4 Table 4 Research studies on nurse entrepreneurs

Reference	Empirical work	Country
<p>1. <i>Andrews GJ, Kendall SA. (2000) Dreams that lie in tatters: the changing fortunes of nurses who left the British NHS to own and run residential homes for elderly people. Journal of Advanced Nursing. 31(4):900-8,. (Database ref)</i></p>	<p>Background: During the 1980's many nurses left the NHS to own and run private residential care homes for the elderly. The withdrawal of guaranteed state funding and introduction of social care markets have had negative impacts on many of these care homes. This study considers the actions and attitudes of former nurse proprietors. Aims: To investigate a gap in research about the relationship between nurses, nursing and residential homes and provide evidence relating to the experiences of former NHS nurses as independent proprietors of Nursing Homes in light of significant policy change through 1980's and 1990's Method: Three-stage survey between 1994-7 of 150 nursing home owners in South Devon. Semi-structured interviews and follow-up questionnaires undertaken 1-3 years following baseline data collection. Analysis of 30/150 (28.6%) nurses. Findings: A range of reasons for home ownership including; being your own boss, perceived benefits of greater responsibility, career control, be in charge, take risks, be a success income generation was a lesser motivator. While small business in the private sector may have seemed attractive to nurses in the 1980's any move into private sector is associated with risk. Social policy conditions may change with concurrent consequences for businesses and business owners. Key negative factors include; financial insecurity, stress, inexperience and lack of management skills.</p>	<p>UK</p>
<p>2. <i>Andrews GJ. (2003) Nurses who left the British NHS for private complementary medical practice: why did they leave? Would they return? Journal of Advanced Nursing; 41 (Database ref)</i></p>	<p>Background: Evidence suggests substantial numbers of nurses are leaving the NHS. Some nurses are setting up and running small caring related businesses in complementary therapy, an area of that has undergone rapid expansion in recent years. Aims: To investigate the motivations and experiences of nurses who have set up services providing CM. Focussing on the significance of nurses pursuing careers in CM moving away from</p>	<p>UK</p>

Reference	Empirical work	Country
<p>also referred to in: <i>Andrews GJ, Phillips, DR. (2005). Petit Bourgeois Healthcare? The big small-business of private complementary medical practice. Complementary Therapies in Clinical Practice. 11(2)-87-104 (Database ref)</i></p>	<p>the NHS and, To put into context evidence associated with nurse recruitment and retention in relation to training needs, stressors of nursing (such as limited resources, changing/ increasing workloads, changing roles) job satisfaction and alternative career options in private practice. Method: Qualitative study using a combined questionnaire (n=63) and semi-structured interview (n=11) approach . Findings: Greater synergy between orthodox and complementary medicine may be one way of addressing shortages of nursing labour whilst meeting evolving consumer health care. Many practising complementary therapists are registered nurses who may be willing to re-enter the formal health service .<i>Key Motivating factors:</i> Having the choice to return to caring nursing type roles, greater work pattern flexibility and autonomy, being able to practice in a better ways, positive experiences of CM compared to OM/ restrictions of medical models. Recognition of a gap in service provision. Interest in alternative treatment methodologies. Personal and professional satisfaction in helping to empower patients. <i>KeyBarriers:</i> Financial insecurity, irregularity of work, reduced income, lack of business skills(associated stress), isolation, loss of sick or maternity benefit.</p>	
<p>3. <i>Lewis, R (2001) King's Fund Nurse-led Primary Care. Learning from PMS Pilots. King's Fund, London, (Grey ref)</i></p>	<p>Background: Evaluation of the 9 first wave, nurse-led PMS pilots in Primary Care that went live in 1998/99. 8/9 pilots newly established providing services where none been before. 5 were in community NHS Trusts, 2 managed by existing GP practices and 2 managed by nurses acting as independent contractors. 6/9 designed to serve specific targeted populations or increase access to under doctored areas. Most common population groups were the homeless, refugees and asylum seekers. Aims: To understand the experiences and perceptions of a group of nurse pioneers as they sought to implement an ambitious personal and professional agenda and to examine nature and characteristics, value systems and relationships of the nurses with other professional and hospital services. Methodology: Evaluation of the progress made in two years since inception through .2 focus groups of nurse leads. Findings: Nurse led care describes culture of professional equity and patient focussed services. Transcends any model of nurse leadership. Generally extended nurse roles are successful, cost effective and achieve high patient satisfaction. Model of enhanced nursing roles not without controversy with resistance and blockages identified</p>	<p>UK</p>

Reference	Empirical work	Country
	<p>in some quarters. Local controversy reported among Drs in relation to nurses challenging traditional practices that has raised ethical debate about potential of a two tier system. Among the positive aspects is the development of new relationships between nurse and Dr and across HC boundaries. Among negative aspects are bureaucratic and legislative issues, such as prescribing, certification, poor management support. A new infrastructure and professional nursing body support is needed to support new nursing roles, provide clarity over competencies, training and QA of NP services.</p>	
<p>4. <i>Chapple, A. (2000). Two years experience of a nurse led pilot scheme: Patients' perceptions. Primary Health Care. 10;10.Dec 2000/Jan 2001:14-17</i> (Database ref)</p>	<p>Background: Working relationships between nurses and doctors in primary care undergoing rapid change and nurses are taking on new roles. Two nurse-led pilot schemes operating for two years are good examples of these changing roles and relationships. Aims: To evaluate whether nurse led PMS provide improved services to disadvantaged groups and to discover patients' perceptions of a nurse-led service. Methodology: Qualitative interview study of 28 patients. Findings: Suggest patients support nurse-led initiatives. Nurses were as knowledgeable as the doctors and they had real choice over who they consulted with. Nurse-led practices provide a viable option particularly in areas where GP's are hard to recruit or where GP turnover is high.</p>	UK
<p>5. <i>Roggenkamp SD, White KR. (1998) Four Nurse Entrepreneurs: What motivated them to start their own businesses. Health Care Management Review; 23:67-75.</i> (Database ref)</p>	<p>Background: In an environment of change, innovators or entrepreneurs emerge to develop new methods and processes of delivering health care in a way that lowers the overall costs of care while improving outcomes. Aims: To investigate the factors that motivate nurse entrepreneurs as well as the characteristics of nurse entrepreneurs and their business ventures. The rationale for health care managers to capitalize on nurse entrepreneurship is discussed as an effective method of strategic adaptation. Methodology: Qualitative study of 4 NE's (3 different types of nursing-related businesses (not specified) who had started their own business ventures less than 10 years ago. Interviews investigated 3 key questions:- primary factors that motivate NE's, what assists or hinders success and characteristics and attributes of individual NE's . Narrative analysis grouped into 20 topics ranked least to most important relevant to their contribution to the research questions. Focus on motivations, behaviours, and attitudes of NE's. Findings: 3 emerging patterns identified. Instigating factors, Business factors (Enablers,</p>	USA

Reference	Empirical work	Country
	<p>Disablers, Characteristics of the business), and <i>Personal factors</i> (characteristics of the NE). Personal motivating factors take form of reward, Financial, Freedom and flexibility, Expert status and leaving a professional legacy.</p> <p>'Instigating factors' included 'nurses' love of particular field of nursing' and was a prevailing theme in how business operated, response to the challenge and evaluation of the rewards of owning own business, risk taking, Assertiveness, and Strong sense of leadership.</p> <p>Barriers within 'Business factor' include; Lack of business skills/business deficiencies and perception of poor preparation for to run business venture.</p>	
<p>6. <i>McCline, R.L., Bhat, S. & Baj, P.</i> (2000). Opportunity Recognition: An exploratory investigation of a component of the entrepreneurial process in the context of the health care industry. <i>Entrepreneurship Theory and Practice</i>, Winter, 81-93. (Grey ref)</p>	<p>Background: This study builds upon the conceptualization of part of the entrepreneurial process that is frequently labelled "entrepreneurial attitude orientation" focussing on entrepreneurial attitudes rather than personal traits.</p> <p>Aims: To investigate the usefulness of two new a new exploratory recognition scales expanded from the original exploratory opportunity attitude scale (EOA) to measure attitude to risk (Entrepreneurial Risk Willingness) and recognition of opportunity (Entrepreneurial Opportunity Recognition) in order to test contextual and behavioural characteristics of Nurse Entrepreneur activity.</p> <p>Methodology: Questionnaire Survey of 515 nurses randomly selected from nurse entrepreneurs registered with the National Nurses in Business Assoc (NNBA).</p> <p>Findings: 139 NE's responded 11 excluded because of missing data. Data was compared between the 99 nurses identified as self employed and the 29 in traditional employee role. The majority were female (88%), 89% were Caucasian and 6/10 had undertaken at least one business course. The EOR scale is a useful tool to discriminate between NE and non NE's and can help classify NE characteristic in terms of achievement, perceived control, innovativeness and self esteem and entrepreneurial opportunity recognition traits. NP's in independent practice are predominantly more personal achievement orientated, desiring to win, achieve and be successful. Measuring themselves by level of success. NP in collaborative practice are predominantly 'affiliators', enjoying team work environment, teaching and working with others measuring themselves by their social care giving, and function as contributors to lives of patients and colleagues. Future research should focus on exploring the multidimensional view of the entrepreneurial process.</p>	<p>USA</p>

Reference	Empirical work	Country
<p>7. <i>Amundsen, S.B.; Corey, E.H. (2004) Decisions behind career choice for nurse practitioners: independent versus collaborative practice and motivational-needs behavior 2000;4:6: 309-315</i></p> <p>(Grey ref)</p>	<p>Background: In response to changing healthcare needs and trends extended and advanced nursing practice roles developed and nurse practitioners are now taking an active role in defining and establishing their career pathways as independent or collaborative practitioners, however little is written about NP's make career choices.</p> <p>Aims: To examine personality information and motivational needs behaviours based around 7 open ended questions that may underlie practice choices for advanced practice among independent primary care NP's nurses.</p> <p>Methodology: Interviews conducted with independent NP's (n= unspecified, recruited from 3 US states not specified) and nurses working in a collaborative practice(n=unspecified). Selection criteria not specified.</p> <p>Findings: Independent NP's are more business focused, achievement orientated and driven towards success presenting patient care as a secondary concern compared to NP's working within collaborative practices. Independent NP's value the freedom and flexibility of independent practice and in recognition of the challenges of and struggles of running their own business, remuneration issues and oncall hours develop strong supportive networks. Conversely , collaborative NP's emphasise the importance of an interactive, team approach to work practice and the benefits of ensuring a family, social and work life balance. Collaborative NP's did not wish to work alone or take the risk of becoming independent.</p>	USA
<p>8. <i>Sao Lang "Jennifer" Leong. (2005) Clinical Nurse Specialist Entrepreneurship. The internet Journal of Advanced Nursing Practice 7(1), 1-7..</i></p>	<p>Background: Changes in the US healthcare industry have created diverse opportunities for clinical nurse specialist (CNS) entrepreneurs. This Literature Review only explores the types, advantages, barriers and implications of CNS Entrepreneurs</p> <p>Methodology: Search of CIHNAL and Ovid (dates not specified) .</p> <p>Findings: 383 articles identified pertaining to nurse entrepreneurs, skill and attributes. Various types of CNS NE identified in diverse specialities. Three main types of business structure described including; sole proprietorship, general partnership and corporation. Subroles of the attributes and skills of a CNS reflect the roles of CNS NE's such as leader, consultant, collaborator, advocate negotiator and expert in marketing and product presentation. Major characteristics include, visionary, decision maker, ,problem solver ,risk taker, self starter and good communicator. Comparison of CNS NE is made to Benner's, <i>novice to expert model</i>. Key advantages include; flexibility and freedom to focus on personal interests, quality and variety of</p>	USA

Reference	Empirical work	Country
	work. Disadvantages include; higher cost of malpractice insurance, lack of hospital priviledges, professional skepticism, start up costs, business acumen.	
9. <i>Bush, N.J. & Watters, T. (2001). The emerging role of the oncology nurse practitioner: A collaborative model within the private practice setting. ONF, 28, 9: 1425-1431.</i>	Background: the role of NP's developed in response to need for advanced practice nursing skills in primary care settings, specifically in paediatrics and has been continually evolving. Shifts in health care have seen advanced practice oncology nursing services moving from the acute care sector across a variety of health care settings including ambulatory , private practice, HMO community and occupational and homecare settings. This Literature Review only explores the emerging role of the Oncology NP as partner in collaborative private practice. Methodology: Search of articles, book chapters and personal experience (databases and dates not specified). Findings: The emerging ONP role can effectively meet both medical and nursing needs of patients. A collaborative model can achieve better patient outcomes within the private practice setting. Major obstacles in the implementation of ONP roles in private practice include; developing a supportive, collaborative relationship with oncology physicians in order to achieve shared care authority, limited/inconsistent prescriptive authority across the states, insurance reimbursement problems and professional role recognition.	USA
An Australian study. Findings reported through two different papers 10a. <i>Wilson A, Averis A, Walsh K. The influences on and experiences of becoming nurse entrepreneurs: a Delphi study. International Journal of Nursing Practice 2003;9:236-45.</i> (Database ref)	Background: The changing Australian health care system is providing increasing opportunities for nurses to work directly with clients in private practice settings. The concept of entrepreneurship as process recognises opportunity and open endeavour in a competitive health care market addressing issues of economics, service access and development of suitable health services. Little is known about private practice (PP) nursing as an area of advanced practice. As more nurses are taking the option to develop private practice the experiences of and influences on nurses currently in PP might be a useful guide to the pitfalls and difficulties that might be encountered. Aims: To increase understanding of Private Practice nursing and generate greater insight into its efforts to improve and maintain quality nursing services within Australian health care system, this paper aimed to elicit and assess consensus on the reasons for nurses going into business and the experiences they encountered in becoming and being a nurse entrepreneur. Methodology : Two round Delphi postal questionnaire using 4 point Likert scaling used to rate opinion statements. Purposive and snowballing sampling approach taken of 106 self employed	Australia

Reference	Empirical work	Country
	<p>nurses recruited through the Association of Nurses' in Private Practice in Australia.(now Nurses in Business). Pilot study undertaken in 10. 1st round included several statements related to influencing factors and entrepreneurial activities and included facility to garner suggestions for additional topics. 2nd round included a summary ranking of topics analysed in 1st round</p> <p>Findings: Round one (n= 59) and Round two (n=54). Important factors for PP included: job satisfaction, being able to use distinctive skills, make a difference to patient care, enabled a return to nursing in line with other life activities. They did <u>not enter into</u> PP because they were unemployable, unable to find work or redundant. PP offered a better proposal than hospital based work, and had the potential for increased income. Possessing previous experience and expertise as thought to be a pre-equisite.</p> <p>Value was placed on autonomy, increased personal and work flexibility.</p> <p>Personal characteristics included: motivation flexibility creativity willing to take a risk, independent nature without necessarily working alone, focus and vision.</p>	
<p>10b. <i>Wilson A, Averis A, Walsh K.</i> The Scope of Private Practice Nursing in an Australian Sample. <i>Public Health Nurs.</i> 2004;21:488-94. (Database ref)</p>	<p>Background: Entrepreneurial activities are those that create new options, involve some risk, require flexibility and instigated as a result of motivation from those with entrepreneurial qualities. This enables nurses to consider private practice as a business development venture.</p> <p>This second paper examines the scope of private practice roles within the Australian nursing profession, and assists in the development of additional ambulatory health services enabling the nursing profession to better understand one group of nurses and promote development of improved strategies to meet demands of health sector.</p> <p>Methodology: Data retrieved from Round two of Delphi Questionnaire (n=54 self employed nurses recruited through Nurses in Business) which is divided into:- socio-demographic, influencing decision making factors, entrepreneurial qualities and scope of private practice(PP).</p> <p>Findings: PP nursing has one full circle from many years ago and a wide range of activities and clinical practice areas were identified. Primary entrepreneurial qualities included; ambition, assertion, accountability and commitment.</p> <p>Entrepreneurship is not confined to PP but it does enable nurses to remain within nursing when leaving acute care sector.</p> <p>Key difficulties include: in building sufficient client base, remuneration issues, setting of suitable fees, referrals and recognition.</p>	<p>Australia</p>

Reference	Empirical work	Country
<p>11. <i>Firkin, P.</i> (2003) Midwifery as non-standard work: Rebirth of a Profession. (Research report2003/1) Albany & Palmerston North: Massey University, Labour Market Dynamics Research Programme. http://lmd.massey.ac.nz/publications/Midwife%20Report.pdf Also reported in <i>Firkin P.</i> (2004). The Cultural Capital of Midwifery: unique foundations for self-employment. <i>New Zealand College of Midwives Journal</i> 30:6-10. (Grey ref)</p>	<p>Background: Interest in non standard working (NSW) has been growing over the past 20 years. As part larger project examining the changing dynamics of NZ labour markets, this study explores the unique area of caseloading midwives particularly in self employment. The concept of entrepreneurial capital is used to examine NSW in midwifery. These resources are described as belonging to 1 of 5 forms of capital human, social, economic, physical and cultural capital that eventually = their total capital.</p> <p>Aims: To explore the experiences of midwives working in non standard ways from greater Auckland area and to expose the multifaceted nature of entrepreneurial activities by highlighting the range of resources that entrepreneurs possess or acquire then employ when running a business.</p> <p>Methodology: Ethnographic study of 10 midwives using face to face interviews (6 were self employed).</p> <p>Findings: Caseloading midwifery is one form self-employment and thus can be approached in business terms. Midwifery philosophy and practice can be conceived as the cultural capital of midwifery. Three broad outcomes include; provision of a detailed account of the mix of entrepreneurial capital unique to independent midwifery, gender dimensions of NSW and the importance of human, social, and cultural capital over financial and physical resources. Childbirth is viewed as normal healthy process and has as its central philosophy woman centred care, partnership and continuity of care. Interest in non standard working (NSW) has been growing over the past 20 years. As part larger project examining the changing dynamics of NZ labour markets, this study explores the unique area of caseloading midwives particularly in self employment. The concept of entrepreneurial capital is used to examine NSW in midwifery. These resources are described as belonging to 1 of 5 forms of capital human, social, economic, physical and cultural capital that eventually = their total capital. This was an ethnographic study of 10 midwives utilizing face to face interviews (6 were self employed). The aims were to explore the experiences of midwives working in non standard ways from greater Auckland area and to expose the multifaceted nature of entrepreneurial activities by highlighting the range of resources that entrepreneurs possess or acquire then employ when running a business.</p>	<p>New Zealand</p>