

**STRATEGIC DIRECTION IN
COMMUNITY NURSING IN
NORTHERN IRELAND**

POSITION PAPER

November 2003

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Strategic Direction in Community Nursing in Northern Ireland

Position paper – November 2003

1.1 Introduction

In 2002, the Nursing and Midwifery Advisory Group DHSSPS began work on developing a strategy for community nursing that would shape the service over the next three to five years. A considerable amount of work has gone into this, against a backdrop of major policy change, changes in the political situation in Northern Ireland, imminent changes in how primary care services will be organised through the new GMS Contract, and significant alteration to the professional register to which all nurses¹ belong.

In this project, we have considered the delivery of nursing services in both community settings and primary care. The artificial division – from a patient's perspective – between community based health and social care, primary care and acute care is a challenge for all of us. Our developing strategy is inclusive of all nurses who deliver care in local settings and in GP surgeries².

The purpose of this paper is to provide an update on progress, share the strategic vision, principles and action points for discussion, and to outline the criteria for application for funding for pilot projects.

1.2 Progress so far

A number of initiatives have been completed, including

- A research report by Queen's University and the University of Ulster on *Community Nursing: Current Practice and Possible Futures*

¹ The term nurse is taken to include all nurses, midwives and health visitors

² This includes district nurses, health visitors/ specialist community public health nurses, community mental health and learning disability nurses, practice and treatment room nurses, nurse practitioners, school nurses, occupational health nurses, community children's nurses and the wide variety of nurse specialists who work in the community and across acute and community settings.

- Two workshops, attended by a range of professionals and others, respectively on visioning the future and on developing pilots for new models of community nursing across the spectrum from health promotion to palliative care
- The sharing of draft strategic principles for discussion widely across the Nurse Leaders' Network, Trusts, Boards and through the workshops
- Agreement by the Board of DHSSPS, and funding to proceed with pilot projects to test new models of service delivery.

1.3 Developments across the UK

Throughout the UK, there is recognition that community nursing needs to be supported to develop the changing and challenging range of services that are now required. Different approaches have been taken in each country.

In Scotland, health visiting and school nursing has been brought together into a single discipline of public health nursing, with a revised educational programme which has a greater focus on public health, whilst retaining registration as a health visitor. There is also a new role of Public Health Practitioner within Local Health Care Co-ops: these new practitioners come from a variety of backgrounds including nursing, health promotion, diabetes, podiatry and dentistry. They play a key role in taking forward health improvement within the LHCC.

A further significant development in Scotland is the piloting of the Family Health Nurse, based on the World Health Organisation model of a generalist practitioner whose work is founded on a comprehensive family health needs assessment and whose role complements that of the GP. Evaluation of the Family Health Nurse pilots in remote areas has revealed different patterns of working. The independent evaluation recommends that careful consideration is required if the role is to be introduced into urban areas³. The Scottish Executive are planning a second phase of development building on the

³ Scottish Executive (2003) *Evaluating Family Health Nursing Through Education and Practice*

evaluation to further support the development of the role in the existing pilot sites and pilot its development in an urban pilot site.

In England, the policy driver for nursing in primary care is *Liberating the Talents*, which proposes three essential core components of nursing in primary care settings: first contact care; chronic disease management/continuing care; and public health. The NHS University is piloting practice based learning programmes in first contact care. Workshops have been held for every Primary Care Trust in England and the framework is being taken forward through initiatives such as 'Practitioners with Special Interests', recruitment and retention projects, GMS/PMS and the CNO review of post-registration education.

In Wales, a Review of Roles and Responsibilities of Community and Primary Care Nursing is underway.

1.4 Strategic direction in Northern Ireland

In Northern Ireland, we propose to develop a model for community nursing that meets the specific needs of the population here. This will include some elements of the above strategies, however our process will be different.

The first point to acknowledge is the excellent work that nurses in local settings are already carrying out. Imaginative new roles have developed, such as specialist nursing posts for the homeless, Nursing Homes and in infection control. These roles and others are beginning to break down the boundaries between different health care sectors. New and expanded roles are rapidly developing for example in the delivery of acute care to people in their own homes and in the range of services that nurses are able to offer in health centres, out of hours centres and to previously under served populations such as Travellers.

Community nurses work in a variety of ways, some focusing on specific conditions or groups, and others providing a much more generalist service, for example in Rathlin Island. Arguably, in Northern Ireland there has been a concentration on developing specialist roles that are crucial in supporting front line generalist services. Together with Scotland and England, we now wish to complement this by valuing and enhancing the skills of nurses whose work is more generalist.

At this time, we do not propose to do this by adopting the WHO Family Health Nurse model. Nor do we intend to develop a formal programme for combining specific groups of community nurses or on developing new titles. However, one outcome of the new approach may be a blurring of roles or combining the traditional roles of two or more specialisms into one job description or post, where this will best meet local needs.

We wish to develop a workforce that is equipped to respond to the increasing demands of first contact care, ongoing care and chronic disease management, while always underpinning this with a public health approach. Nurses will be working in new settings such as intermediate care centres, drop in clinics, treatment and diagnostic centres, and out of hours centres. We envisage a workforce that will be able to provide advanced generalist services, in teams with a range of skills. At the same time, there will be specialist support in clinical areas such as diabetes and epilepsy and for identified groups such as the homeless. Extended and supplementary prescribing by nurses will be an important element in the range of skills needed for nurses to complete episodes of patient care.

We need to encourage everyone working in primary and community health and social care to think first of what the person or community needs, and then what we, together, can do about it. Thus, titles become less important and patient journeys become more important. In working together, we need to combine the strengths of the voluntary sector with those of the many professionals who work in the statutory sector. Where private health or social

care is involved, it is vitally important that we have systems in place to ensure consistent standards, continuity and communication across the different areas.

What we need to do is build on the developments that are already taking place. We need a regional steer that will drive the service in an agreed direction, while still allowing for the variation that is required to meet needs in individual areas.

To achieve this, a draft strategy has been drawn up, as presented here. This is designed to be a working document that can be tested and developed through a process of piloting new models of service delivery. The new models will incorporate the vision and principles of the draft strategy, and be carefully evaluated. If successful, they will then be rolled out.

1.5 What we know

- Research⁴ has demonstrated that community nursing in NI is active in the areas of health education and primary, secondary and tertiary prevention. There is much less activity in the areas of health protection, healthy public policy and community development
- The research report *Community Nursing – Current Practice and Possible Futures*⁵ suggests that enabling factors for new ways of working might include
 - increased resources in terms of time, staffing and administrative support
 - more effective leadership at all levels
 - reconciliation of trust and GP priorities and demands
 - clear goals
 - improved educational opportunities

⁴ Poulton B, Mason C, McKenna H, Lynch C and Keeney S (2000) *The Contribution of Nurses, Midwives and Health Visitors to the Public Health Agenda*. Belfast, DHSSPS

⁵ Turner J, Poulton B, Lazenbatt A, Patton L and Curran C (2003) *Community Health Nursing. Current Practice and Possible Futures*. Belfast, DHSSPS

- better access to ICT and more appropriate forms of data collection for monitoring purposes.
- The above report cites Lazenbatt^{6,7} and lists the following as indicators of successful public health interventions:
1. Approaches/ partnerships:
 - intensive
 - multifaceted
 - partnership/ health alliance; inter-agency working
 - multidisciplinary team working
 2. Evaluation tools
 - evidence based
 - use of previous audit
 - use of previous evaluation
 - prior needs assessment
 3. Resources
 - Settings – embedded in a variety of settings
 - Importance of delivery agent
 - Training of delivery agents
 - Use of support materials
 4. Individuals/ communities/ organisations:
 - A holistic approach to health
 - Empowerment
 - Culturally appropriate.
- An extensive review of systematic reviews by Dundee University funded by the Scottish Executive⁸ demonstrated the following features of successful public health interventions:
- Educational interventions often increase health knowledge, and interactive approaches are often more successful than didactic

⁶ Lazenbatt A (1999) *Targeting Health and Social Need – Manual for Evaluation in Practice*. Belfast DHSS, Stationery Office isbn 337 084696, NI.

⁷ Lazenbatt A (2002) *Handbook on Evaluation for Healthcare Professionals*, London, Rontledge

⁸ Scottish Executive (2001) *Nursing for Health. The effectiveness of Public Health Nursing: a Review of Systematic Reviews*.

methods. However the effect of increased knowledge on behaviour is at best uncertain

- Behavioural change is more likely to occur when education or counselling is combined with environmental modification. This includes legislative change and the provision of the means to modify behaviour e.g. improving building design, providing safety equipment, providing health technologies or changing service provision
 - Effective behaviour change strategies which are based on theoretical models from the disciplines of psychology and sociology are more likely to be effective. Skills training is a desirable component of behaviour modification interventions
 - Multi-agency strategies are more likely to succeed in modifying behaviour. This may involve collaboration with other health professionals and those from non health sectors such as social workers, housing officials, teachers, peers and family members
 - Interventions targeted at high risk groups are more often successful than interventions delivered to the general population. High risk individuals may perceive interventions to be more relevant and may be more motivated to change
 - Many behaviour changes require long-term interventions to achieve and sustain health gains.
- *Health for All Children*⁹ recommends an increase in emphasis on health promotion in areas such as accident prevention and breastfeeding, and a reduction in the number of routine technical screenings by health visitors and school nurses. The ‘Hall 4’ recommendations will be implemented in NI from April 2004.

1.6 The policy context

DHSSPS is developing a twenty year regional strategy for health and wellbeing. One of the biggest challenges is to build a responsive, coherent

⁹ Hall DMB and Elliman D (2003) *Health for All Children. Fourth Edition.* Oxford: OUP

and integrated services. This is also a challenge for us. The Service Improvement Unit at DHSSPS has funded a number of projects that use process mapping to smooth patients' experiences as they move across settings. Innovative work is being carried out in community pharmacy¹⁰ that uses public health approaches to reach out to local populations. It will be important that our pilot projects complement this work and avoid the potential error of duplicating the same ideas on a uni-professional basis.

Investing for Health provides a strong framework for cross-sectoral public health effort. Our community nursing strategy needs to align with this so that nursing energy contributes to the overarching goals of increasing life expectancy and reducing inequalities.

The new GMS Contract will have a major impact on the way that primary care services are delivered. Funding from April 2004 will be allocated to practices rather than individual GPs. Nurses, if they wish, and others, can become business partners. It is therefore important that we think in terms of the GMS [General Medical Services] Contract, and not, as formerly, the GP Contract. Practices must offer essential services such as management of patients who are ill or seeking health advice, terminal illness care and chronic disease management. They can choose whether or not to provide additional services including cervical screening, vaccination and immunisations, child health surveillance and minor surgery. The provision of enhanced services is also optional including extended minor surgery and more specialised services undertaken by GPs or nurses with special interests. There will no longer be a requirement for all practices to provide out of hours services.

Community nurses will have an increasingly important part to play in providing first contact and out of hours services, and this will need advanced skills. A quality framework will reward practices for quality care in four areas: clinical standards, organisational standards; experience of patients; and additional services. The specialist skills of nurses will be crucial to achieve clinical standards in areas including CHD, stroke and TIA, hypertension,

¹⁰ DHSSPS (2003) *Building the Community-Pharmacy partnership. One Year On – March 2003*

diabetes, COPD and epilepsy. In the future, nurses will deliver more of the front line generalist care, with GPs concentrating increasingly on complex cases. The key paragraphs that refer directly to nursing in the Contract are at 4.19 and 4.20 (see appendix 1).

Running alongside these developments, DHSSPS is developing a Strategy for Primary Care. The Community Nursing Strategy will be one of its sub strategies, together with the community pharmacy strategy and others that are likely to be initiated in due course. Close links between NMAG and Primary Care Directorate should ensure consistency between the two as they develop.

Structural changes to the HPSS were proposed in Developing Better Services, while corporate and research governance structures are currently undergoing major reorganisation. The backdrop to all of this is a Review of Public Administration across all government and statutory bodies, which will advise on the best structural configuration to meet the future health, educational, civic and other needs of the NI population.

In the midst of all this change, community nurses continue to care for the most vulnerable people on a daily basis, and to work with families and communities on local health issues. A key message must be that we need to retain our focus on our core vocation – working for health and caring for the sick - while also being adaptable and proactive in meeting and leading change.

1.7 Vision statement – for discussion and development

We will develop a community nursing service where the needs of communities and patients shape the service. The service will enable people to live healthy lives - nurses will work with others in identifying need, providing health information and clinical care and in helping to create circumstances where health, as far as possible, is a reality for everyone, especially where poverty limits people's choices. People will be able to obtain services from community nurses and nurses in primary care settings as soon as they need them, conveniently, and at home if this is what they need. There will be a

feeling of trust and respect between nurse and patient or community, at each encounter. Patients will have to see as few different professionals as possible, in as few different buildings as possible. We will provide a service of which we are justifiably proud, and that is amongst the leading community nursing services worldwide.

1.8 Principles

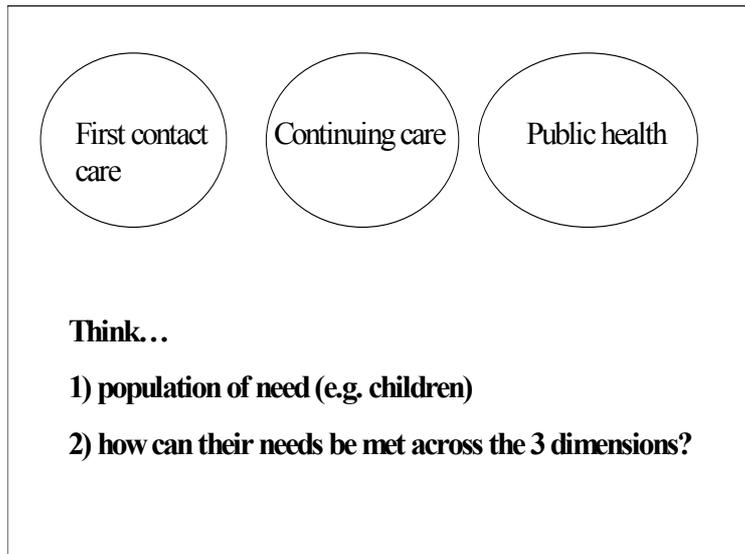
The principles underpinning the draft strategy are:

Northern Ireland will have a community nursing service for primary care that:

- Is increasingly a **first point of contact** for patients/ clients
- Is **flexible**, to work across boundaries, in new settings and to take on new demands
- Has a **wider range of competencies and greater variety of roles**, dealing with identified communities of need
- Is **client/ patient centred** – focusing on assessment of need and client journey/ pathways
- Has **devolved power and decision making** to teams of nurses and multidisciplinary teams, locally, with increased opportunities for leadership roles at local level
- Is **underpinned by public health principles** and thinking
- Is **‘connected’** across disciplines, professions and sectors.

1.9 A model for nursing in the community and primary care

We consider that an adapted version of the framework for nursing in primary care presented in *Liberating the Talents* will be useful here. The modified model is presented below



1.10 Issues and challenges

Health care in GP surgeries is provided by both GP employed nurses (practice nurses and nurse practitioners) and by Trust employed treatment room nurses. Treatment room nurses may find themselves in an uncertain situation as their work under the new GMS contract increasingly responds to the requirements of the practice, while their terms and conditions are set by the employing Trust. Indeed, it is not certain who exactly practices will employ/ contract with to meet the requirements of the quality framework. In these circumstances, the Department, Boards and Trusts need to acknowledge the significant input of treatment room nurses and support them in fulfilling their role. We suggest that a review of the treatment room nursing service should be undertaken urgently to assess whether the current structures best facilitate this input.

There are particular challenges for workforce planning across primary care. The new GMS contract gives unprecedented flexibility to practices in deciding what services they wish to offer, or not. For example, if large numbers of GPs decide not to offer out of hours provision, Boards may contract nurses or private companies (that employ nurses) to provide out of hours services.

This has the potential to destabilise the workforce if community nurses – a scarce resource – are drawn away from Trusts.

As nurses increasingly undertake tasks that were previously carried out by doctors, risk management and clinical governance become ever more important. While all nurses are bound by their Code of Professional Conduct, it is vital that employing practices understand this Code and that they facilitate education and training. It will be important that expanded roles are developed to meet the needs of patients more smoothly, and not driven by a desire for role substitution. The Contract clearly states that practices will be rewarded under the organisational quality standards for working to *Agenda for Change* (paragraph 4.19).

1.11 Education

A responsive, flexible workforce will require a responsive, flexible education system.

In the immediate future, The Nursing and Midwifery Council will set competencies for the new third part of the Register for Specialist Community Public Health Nurses. We will be engaging with the NI Practice and Education Council throughout the course of this project.

In the longer term, we recommend that there should be a review of education for nurses who work in the community and primary care. New combinations of skills will be needed and it is likely that nurses will want to add to their portfolio of skills as new conditions and situations arise. Job descriptions will become more important in defining what community nurses do. Identified need on the ground will lead clinical and public health activity, therefore a one year community nursing qualification for life may be less useful than an incremental build up of skills in response to the clinical and social setting.

A discussion paper on the future direction of post registration education and development in primary care nursing is included in appendix 2

1.12 Action

- Funding has been secured to pilot 8 new models of service delivery in different parts of NI
- A Project Director and a Project Officer will be appointed in early 2004 to oversee the work
- A multidisciplinary steering group will be established
- A smaller working group will be responsible for the operational aspects of implementing the pilots, including quality assuring the process at each stage
- A communication and consultation strategy will be developed, within the Department, the wider HPSS and beyond
- Based on the strategic vision, principles and model, and in keeping with the policy context as outlined, bids will be sought for the pilot projects, in early 2004.

It is likely that the pilots will be required to demonstrate that they:

- (i) Are consistent with the strategic direction for community nursing as outlined in this paper
- (ii) Meet the characteristics of a successful public health intervention (see earlier section on 'what we know')
- (iii) Promote the emerging policy agenda
- (iv) Have sound evaluation processes built in from the start
- (v) Have the potential to be transferable to other primary care settings.

In addition, proposals will be welcome if they

- Link clearly with Local Health and Social Care Groups
- Engage GPs and support the new GMS Contract, demonstrating collaboration between trusts and GPs in service delivery and workforce planning
- Take a patient journey/ pathway approach to care

- Link primary care/ secondary care/ the independent sector. For example shared projects across primary and secondary care would be welcome, as would projects that create/ build on new models of intermediate care, nurse led walk in centres, or similar
- Build on existing service developments that promote the strategic principles and public health characteristics as outlined above
- Focus on one or all of the three key areas: first contact care; continuing care; public health, and/ or the interfaces between them
- Promote developing roles in nursing, for example independent and supplementary prescribing
- Clearly demonstrate a multidisciplinary approach, linking with and building upon public health developments in other areas e.g. community pharmacy.

Further detail and a formal trawl will follow in early 2004.

1.13 Outcome

This project will create a community nursing service that is focused on delivering the outcomes that citizens need and expect, affirming essential principles of equality and integrity, and characterised by responsiveness, flexibility and efficiency. The reconfigured service will give citizens easier access to health care and allow people to be seen more quickly. The redesign will help to create a workforce that is ready to lead new developments such as nurse led drop-in clinics, intermediate care centres and more opportunity for people with complex clinical conditions to be cared for at home. Nurses will be equipped to provide same day care and a considerable amount of first contact care, so that patients will be more likely to see just one, multiskilled health professional. Independent and supplementary prescribing by nurses will be expanded, as a key skill for completing episodes of care, and providing continuing care and chronic disease management.

APPENDIX 1

New GMS Contract 2003

Supporting Practice Staff

- 4.19 Organisational standards in the quality framework will reward practices for ensuring employment standards comply with good human resources practice in line with *Agenda for Change* principles that are expected to apply to non-medical staff and to prevent exploitation.
- 4.20 **Nurses will be given the freedom and support to work with GPs in new ways and to take on more advanced and specialised roles:**
- i. all practice-employed nurses should be supported to participate in clinical supervision and appraisal and to have access to professional advice and continuing professional development and to IM&T
 - ii. these new roles taking on, where appropriate, **more advanced and specialist roles in first contact care, chronic disease management and preventive services** will need to be supported by the necessary skills and knowledge provided by training and education and an understanding by the nurse and GP of the Nursing and Midwifery Council Code of Conduct
 - iii. in line with a practice-based approach we envisage that the new GP performer list arrangements described in chapter 7 will, over time, be extended to other professions as appropriate
 - iv. the global sum payment arrangement will enable practices to develop greater skill mix with more registered nurses, pharmacists (subject to rules governing conflict of interest) and allied health professionals providing opportunities for a range of professionals to work at all levels as part of the practice team. **The skills and expertise of nurses in general practice working at a more specialised level will be developed.** Nurses and others should be fully involved in practice decision-making that impacts on their work
 - v. the quality framework will apply to the practice team rather than separate professionals.

APPENDIX 2

DISCUSSION PAPER - THE FUTURE DIRECTION OF POST REGISTRATION EDUCATION AND DEVELOPMENT IN PRIMARY CARE NURSING

1. Introduction

In order to respond to the changing context of primary care, this paper seeks to stimulate a discussion on a more flexible and responsive approach to the education and development of nurses working in primary care. It does not represent the policy of the 4 health departments. While the emerging policy context is increasingly different in each of the four UK countries, there are similar drivers dictating the development of primary care nursing practice. A consistent approach to the education and development of primary care nurses is essential to allow a degree of local flexibility whilst maintaining the freedom of movement of nurses pursuing their careers across the UK.

2. The context

Policy developments in each of the UK countries have common aims of improving access, reducing inequalities, managing hospital demand and improving health. This is taking place within a context of changing health needs and public expectations, new technologies and increases in chronic illness.

3. Drivers for change

The changing policy context alongside changes in the demography of both the population as a whole and the nursing workforce result in a number of drivers which challenge the current approach to educating and developing primary care nurses. Specific drivers include:

Flexibility to respond to patient and community health needs

Rigid boundaries between existing disciplines, hospital and primary care and health and social care are not helpful. Policy is leading towards increasing integration and the development of more patient centred services, with nurses completing more episodes of care by using expanded skills, enlisting, where appropriate the specialist skills of other professionals or agencies. This will increasingly mean service planned and delivered on the basis of need rather than professional title.

Career structures

There is a need for more flexible career structures that enable progression through continuous development rather than a series of steps. In primary care, this would mean enabling careers that progress from initial registration towards increasing levels of knowledge and skills, with individuals able to progress at their own pace. At the same time we need to make it easier for nurses to move between hospital and primary care.

Structure of the workforce

The current workforce in primary care nursing has the bulk of nurses in the middle of the structure at specialist practice level. In some disciplines, most notably health visiting and practice nursing, there is little skill mix, with most practitioners at this level. In order to respond to future demands, there will need to be a shift in the shape of the workforce to encompass a wider range of knowledge and skills from registered nurse to more advanced level practice.

Workforce modernisation

Contractual and employment arrangements for the whole primary care workforce are changing. Agenda for Change heralds a shift from reward on the basis of qualifications towards a more flexible approach to rewarding the acquisition of skills and knowledge relevant to the role. The new GMS contract removes some of the former barriers between individual disciplines requiring and enabling new approaches to the delivery of primary care services.

Generalist versus specialist

Current structures are based on developing mutually exclusive specialisms, with a requirement to become increasingly specialised in order to progress careers. Future practice will need to allow for far greater flexibility in this model, with recognition of both breadth and depth of competence. This might include supporting specialisms at junior levels of the workforce as well as the development of high level generalists.

Emerging areas of practice

Practice in some areas is expanding rapidly. This is particularly the case in relation to nurses taking on roles as the first point of contact with patients with undifferentiated conditions. Education and development support needs to be able to respond rapidly to supporting and enabling new developments in practice within an overall framework.

4. Key principles for future primary care nurse education and development

Common route

There should be a common career route for all primary care nurses, with education and development based upon three core elements:

- First contact care: Undertaking acute assessment, diagnosis, care, treatment and referral.
- Continuing care: Planning and managing interventions, care/case management and chronic disease management.
- Public health: Planning and delivering preventative programmes at individual, family and community levels.

The combination of these elements of practice within any individual nurse's role will vary according to local needs and priorities rather than being prescribed by titles. The range of practice undertaken by each nurse would reflect the needs of the particular community of need that they worked with. So a mental health nurse, would work primarily with a community with mental health needs, but would encompass varying elements of the three core functions of first contact, continuing care and public health within her role. The proposed route is summarised in figure 1 below:

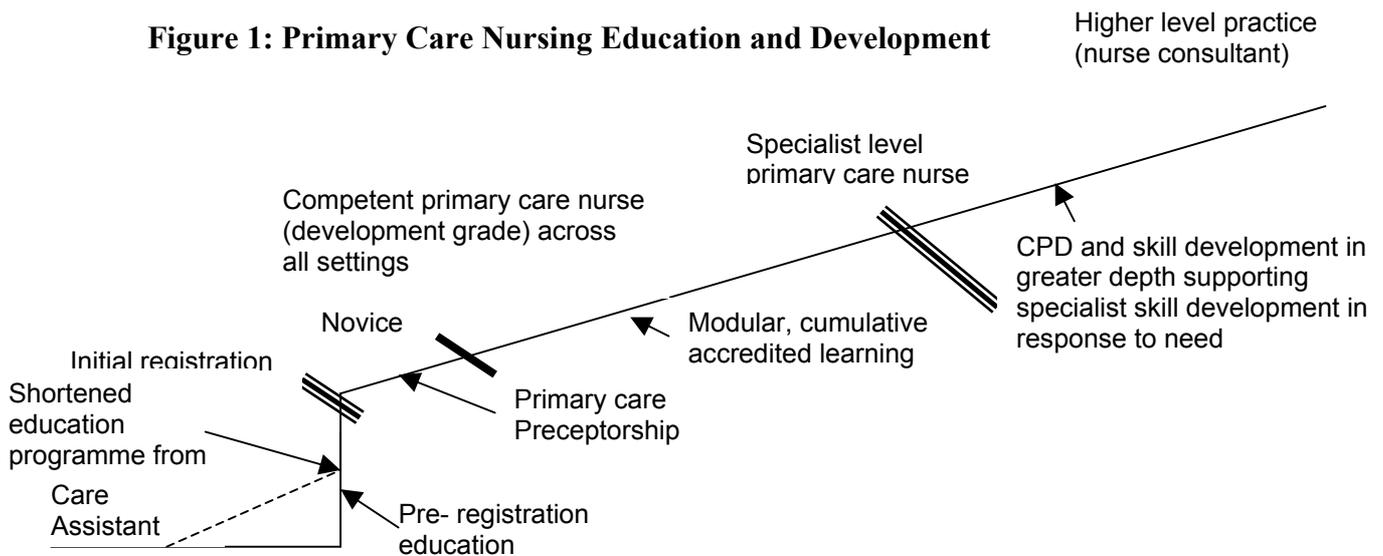
Modular accredited education

Career progression would need to be supported by a modular educational approach allowing learning to be accredited and cumulative.

Reward for gaining knowledge and skills

Agenda for Change creates a new reward structure for nurses, based on the acquisition of knowledge and skills. Any new educational structure should support this approach. Key elements of the educational route throughout this proposed new model would be the ability to search for and apply appropriate evidence and an understanding of the limitations of personal competence.

Figure 1: Primary Care Nursing Education and Development



==== Indicates a formal gateway requiring the demonstration of knowledge and skills and a registration/record on the NMC register. This may change in the light of NMC review of post-registration regulation

Career progression

There should be a continuous progression for nurses in primary care, through the acquisition of knowledge and skills. Over time, the shape of the workforce should change to better reflect local need and to support a clear career pathway for primary care nursing with more primary care nurses and support staff and greater variation as people move across the Agenda for Change bandings.

Level of practice

Current use of the term specialist practitioner to describe a level of practice rather than degree of specialisation is confusing and rewards specialisation as the only means of progressing. Education and development should be within a framework that recognises the achievement of knowledge and skills throughout a nurse's career. The principal differentiating features of practice at a specialist level should be leadership, advanced clinical competence, needs assessment, use of evidence, case management, teaching and mentoring and the ability to work across boundaries in the planning and delivery of care, rather than specialisation in a particular field. Achieving this level of practice would require nurses to demonstrate competence across the three functions outlined above.

Diversity of roles

Whilst there is a single educational model and a single gateway to practice at a specialist level, that would not mean that all nurses would do the same job. Rather it should support increasing diversity of primary care roles in response to local needs, within a common core set of principles and functions that apply to all primary care nursing roles. The range of such roles and the potential for flexibility between them would need to be supported by a diverse range of educational modules.

Job descriptions, person specifications and workforce planning

Moving away from tightly prescribed roles will require greater attention to development of job descriptions and person specifications with an agreement on appropriate targets and outcomes for each post. Workforce planning would also need to be very sensitive to changing local need. This will require improved professional and clinical support for nurses and robust clinical governance frameworks, especially for nurses taking on new roles.

Specialisation

Individual nurses at all levels may have specialist areas of expertise that should be developed and supported. The development of specialist expertise should not be confused, as it is at present, with level of practice. Beyond the gateway for specialist level practice there should be further routes to develop competence in each of the three functions. Development at this level is likely to represent additional depth in a particular area of practice, supporting the development of specialist expertise as a resource for primary care nurses.

5. Some key questions

Regulation

How could the proposed new model be regulated effectively by the NMC?

Common core

Is there a common core of skills and knowledge that we would expect all primary care nurses to have? How might these be defined?

Educational programmes

How could current programmes be re-designed to become a menu of independent modules and support the acquisition of clinical skills and knowledge?

Preceptorship, mentorship and supervision

Do we need new models and approaches to support and supervision in order to support the proposed new approach?

Potential barriers

What barriers might need to be overcome to gain support for this new approach?
How do we ensure GP employed nurses have access to the same educational support and career opportunities as Trust/ PCT employed nurses?.

Workforce planning

What developments in workforce planning at local and regional levels would be required to support this new approach?

Impact on pre-registration education

What impact would such an approach to post registration education and development have on pre-registration education?

This is an adapted version of a paper produced by the four UK Nursing Officers -
Primary Care & Public Health
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