Chapter 1 The Context of Primary Health Care Nursing

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The changing context of service provision

The population of the UK is projected to increase by approximately 7.2% over the period to 2016. The key drivers for population increase within the UK relate to greater life expectancy and migration, particularly from eastern Europe. Other key demographic challenges relate to an increasing older age population (over the age of 65), which will increase from 16% in 2006 to 22% by 2031 (Office for National Statistics 2007). The age of the working population will also increase during this period, demonstrating unforeseen lifestyle patterns, which in turn will impact on those people of state pensionable age.

According to Mathers & Loncar (2006) the ten leading causes of death by 2030 will be ischaemic heart disease, cerebrovascular disease, upper respiratory tract and lung cancers, diabetes mellitus and chronic obstructive pulmonary disease (COPD). Within the top ten leading causes of death will also rank dementias, unipolar depressive disorders, alcohol use disorders, stomach and colon cancers and osteoarthritis. The combination of longer-term physical disorders and psychosocial challenges will demonstrate the importance of integrated service provision and workforce capability and capacity to respond to presenting co-morbidities. Other worldwide challenges relating to infectious diseases, such as human immunodeficiency virus (HIV) infection and tuberculosis, will provide additional pressures on our health care systems.

Lord, Professor Ara Darzi, is his review of health care for London (NHS London 2007) identified the importance of promoting self-care and in encouraging patient and user involvement in health care prediction and co-treatment. In his report he noted the major challenges facing the health of the population regarding sexual health, obesity, smoking and alcohol/substance misuse, all of which place a heavy burden on the state health care system and contribute to the incidence of dual diagnoses and longer-term health care conditions.

The expectations of higher service response from the health service and its professional workforce also continue to rise, particularly as service users engage more fully in the determination of the shape and scope of local health care provision. Sang (2005), for example has written of the important role that members of the public are now making to the governance of the National Health Service (NHS), mainly through ‘ownership’ of NHS foundation trusts and through engagement with expert patient programmes. NHS trusts, in turn, are now responding more purposefully and seriously to user and patient expectations and are required to publish action plans in response to local and national patient satisfaction surveys and to demonstrate compliance with local service user requirements and feedback. Associated with the rise in consumerism and user engagement is a marked improvement in the capacity and capability of the NHS to respond to user complaints and to enhance governance procedures. Even more challenging to the NHS, however, is the increased number of litigation cases presented by patients seeking recompense for less than satisfactory care experiences.

So how does society and its associated health and social systems respond to such challenges? In the first place it can be assumed that societal
change moulds the institutions that are created to respond to the needs of the population. Demands change over time and in so doing socio-demographic factors drive the process of change that in turn requires the NHS to adapt its operational base. Examples of such changes relate to the needs of an increasingly ageing population, a reduction in the number of available informal carers, advances in scientific knowledge and technological innovation, and a heightened awareness of ethical challenges (such as gene therapy, stem cell research, embryology and euthanasia).

The impact of change, stimulated by a growing demand for flexible, high-quality services provided within local communities will inevitably re-mould the NHS of the future. Resources are already being moved to the community at a rapid rate and health service commissioners and providers are now required to demonstrate that the care they purchase and deliver is effective and responsive to consumer need (Department of Health [DH] 2006b). It is perhaps in the primary and community care sectors that change has been most rapid, demanding the creation of innovative workforce solutions and service reconfigurations. Lord Darzi in his vision for the future of these services has recognised the challenge that these changes demand and has called for the implementation of a new national board that will include community nurses to ‘drive the overall programme of work and ensure that we continue to engage staff in developing and implementing the vision’ (DH 2008d).

Key features of our contemporary society suggest that a focus on health promotion and public health is required since:

- People are living longer and healthier lives and are better informed about their needs and expectations of the health service.
- Advising and supporting patients to make positive choices about their health status is prominent with particular regard to promoting self-management.
- Demand to enable people to remain at home is rising, thus placing emphasis on integrated care, self-management of longer-term diseases and supporting healthy lifestyle choices and self-care in the community (supported by robust, integrated case management principles and social service direct care payments).
- Significant emphasis has been placed on increasing social inclusion and valuing diversity for socially excluded groups, i.e. those least likely to access health care, and on the reduction of health and social care inequalities experienced by significant groups within our population.
- Geographical diversity demands local adaptation of national health care solutions (particularly within the context of devolved government to the four countries of the UK).
- Consumers and practitioners are becoming increasingly dependent on new technological solutions, e.g. tele-medicine, advances in bio-engineering, NHS Direct and web-based information systems.

In 2008, the government outlined its most challenging reforms for the delivery of health care in England, since the publication of The NHS Plan in 2000, which at that time was supported by the introduction of new NHS structures, including the inauguration of primary care and foundation trusts. In 2008, Health Minister, Lord Ara Darzi, building on the principles of community/primary care enshrined within the NHS and Community Care Act 1990, outlined a reformed strategic framework for the provision of all health services in England, focusing specifically on the major role that primary care trusts (PCTs) will play in the future as both commissioners and, where desirable, providers of local, innovative services (DH 2008a). Current frameworks for the design and delivery of responsive primary care services are built on the principle of ensuring the existence of clear, national standards, supported by consistent evidence-based guidance to raise the quality of care provided by the health and social care services. (DH 2000a, 2008b). Ara Darzi’s new vision for the NHS (DH 2008a) sets out the rationale for the introduction of improvements in the way in which care is provided throughout the NHS and identifies the need for
decisions relating to primary care to be made on the basis of the best evidence and research-based practice, interfacing appropriately with self-care and more specialist diagnostic and treatment provided by secondary and tertiary care providers. The details of the proposals for new locally designed services were previously outlined by the government in a major paper entitled Our Health, Our Care, Our Say: A New Direction for Community Services (DH 2006b), which included emphasis on the implementation of consultation with users of services and empowered frontline staff to identify robust indicators of personal performance while obtaining greater access to control over the allocation and management of the resources required to deliver services. Other critical issues raised in this paper were the concept of user/patient choice of clinician/source of advice, choice of care package, choice of appointment time and location. Associated with choice has been a major drive to reduce waiting times for outpatient appointments, emergency department triage and treatment, and hospital admission. New targets have also been set for cancer treatment and access to other diagnostic and clinical care services. Lord Darzi’s review went one step further and outlined a new vision for the provision of primary and community care services (DH 2008c). The review confirmed the significant role that primary care and health promotion plays in the reformed health economy and emphasised that our focus should be on health outcomes, user engagement and in the design and implementation of healthy communities and lifestyles at school, at home and at work (DH 2008c).

These policies have pledged to ‘break down’ organisational barriers and to forge stronger links with local authorities, thus placing the needs of the patient/client at the centre of the care process. In so doing, a new foundation has been laid on which to unite the principles of seamless care delivery and in particular the provision of self-directed care/direct payment packages, based on case management principles (DH 2008e). In practice this will require the provision of new inter-sectoral solutions to ensure that care is delivered between health and social service agencies through the development of positive partnerships and integrated case assessments between statutory agencies, consumers, their representatives and with the voluntary and independent sectors to provide a positive choice in the provision of services. Emphasis on primary care has been reaffirmed in that, wherever possible, care should be provided as close to the person’s home as possible.

The primary care vision for the next decade

At the heart of the government’s reformed health care strategy is the greater focus placed on the delivery of services in primary care, underpinned by a new relationship between health care professionals and patients/clients though the promotion of supported self-care management. Accompanying this philosophy of care is the recognition that many patients present with complex conditions, arising from co-morbidity (DH 2008c). According to Labour Government (Brown 2008), the NHS of the future:

‘will do more than just care for and treat patients who are ill – it will be an NHS offering prevention. It will not be the NHS of the passive patient – the NHS of the future will be one of patient power, patients engaged and taking greater control over their own health and their healthcare too.’

Among the key reforms resulting from Professor Ara Darzi’s fundamental review for NHS are (DH 2008a, pp. 9–14):

- The creation of an NHS that “helps people to stay healthy”
- PCT requirements to commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations
- A coalition for Better Health, with a set of new voluntary agreements between the Government, private and third sector organisations on actions to improve health outcomes
- Support for people to stay healthy at work
Support for GPs [general practitioners] to help individuals and their families stay healthy
- Extended choice of GP practice
- Piloting of personal health budgets
- Care plans to ensure that everyone with a long-term condition has a personalised care plan
- Introduction of a new right to choice in the first NHS Constitution
- Guaranteed patient access to the most clinically and cost effective drugs and treatments
- Measures to ensure continuous improvement in the quality of primary and community care
- The creation of new partnerships between the NHS, universities and industry
- The provision of strengthened arrangements to ensure staff have consistent and equitable opportunities to update and develop their skills’

The new health service reforms have been underpinned by greater investment in hospital building programmes and in target/standard setting accompanied by matching increased diversity of supply with an ability to respond to the new diversity of demand in preventive and curative medicine—tackling the underlying causes of health inequalities as well as providing the best care. Decreased tolerance of failing services will also be a core component of the government’s strategic health care plan. A new quality commission will therefore be introduced with tougher powers to impose fines and close down services in the case of poor standards. Foundation hospitals will also be able to take over failing hospitals to turn around their performance and in the case of primary care, there will be greater diversity of supply and strengthening of the power of PCT commissioners to ensure that GP or community health care services can be improved or replaced where they fail to respond to local patient/user demand.

Major advances in technology and bioengineering have also brought about significant changes in treatment patterns and modes of delivery. For example with cutting-edge techniques – ranging from genetics to stem cell therapy – and life-saving drugs to prevent, alleviate or cure conditions such as Alzheimer’s disease, it is likely that many of today’s diseases will succumb to either eradication or amelioration. Investment in the implementation of world-class research programmes will accompany the government’s health care investment plan and new academic health science centres will be sponsored for implementation within our most prestigious foundation trusts and their partner universities. These will facilitate the discovery of new technologies, which, in turn, will enable clinicians the ability to diagnose and intervene at the earliest possible opportunity.

Similarly new alliances will be developed with our emergency care services (e.g. the Ambulance Service) to equip paramedical staff with the requisite skills to treat people experiencing a heart attack with life-saving drugs in their own homes or to provide emergency interventions for longer-term conditions outwith hospital specialist treatment units. For others, attendance at specialist treatment centres will become the norm. One such example if of stroke patients who now receive immediate treatment with the latest anticoagulant drugs in specialist stroke centres, thus extending their lives and enabling many people to lead an independent life. Other patients will benefit from attendance at new trauma centres.

There will also be improvements in the way in which the 15 million people in England who present with longer-term diseases, such as asthma, heart failure, diabetes or psychosocial challenges. The people who care for these service users – the ‘carers’, also require additional support and ‘seamless’ access to services. In some cases personal budgets and direct payments will be made available to enable individuals and their families to purchase responsive care packages directly. The use of personal health and social care budgets will underpin reforms of our social care system.

Many of the people who will benefit most from new care packages will present with ‘lifestyle’-related diseases such as diabetes, cardiovascular disease, stroke and some cancers. In order to combat the rising trend in such conditions,
the health service will work in close partnership with patients and carers to co-design and co-deliver effective preventive and direct treatment services, aimed at encouraging the population to take their own health ‘seriously’. In order to achieve this objective more patients will become engaged with their care by managing their own conditions, taking advantage of support offered by GPs and nurses in their home or on the high street, and by exercising more control over their life and care. Greater emphasis on what we eat, and participation in sports and leisure activities, will also be encouraged – presenting a significant challenge for the way in which primary care nurses discharge their role and responsibilities.

There will also be opportunities for the provision of extended screening services, for example for colon cancer and for breast cancer. An increasing number of patients will also access NHS direct, the internet and digital television to improve their access to evidence-based information about their health. Others, through the use of personalised budgets, will take control of their care packages and manage their care plan directly, rather than having to rely on others. By so doing, a greater range of patients will become increasingly empowered, giving them a greater say in their care, particularly in the later years of their lives.

Such fundamental changes in health care policy and process will require primary services to adopt new flexible and responsive approaches and to develop new partnerships with the voluntary and private sectors where they can contribute and innovate. Greater synergy will also be required between acute and primary care, and between health and social care. New and dynamic approaches to PCT commissioning will be needed to deliver such changes, focusing on patient choice, direct payments (DH 2007, 2008c), quality provision and market contestability.

The enactment of this policy has reduced patient/client dependency on inpatient or long-stay residential care in favour of seeking the development of a range of options based on local need, which will be flexible enough to meet the demands of service provision required by local people in their neighbourhoods. Clinicians are therefore encouraged to work in close partnership with their patients and clients with the aim of making them more accountable for their practice and interventions.

At a strategic level the NHS now requires all strategic health authorities to secure significant improvements in the way in which services are delivered to the population, emphasising the promotion of positive health and the promotion of high-quality care in the community. In order to provide these services, strategic health authorities must demonstrate that providers offer/commission a range of services for their clients and families as equal participants, whenever decisions that will affect their lives are involved. Such principles now underpin the NHS philosophy and form the basis of the government’s ‘reformed’ health and social care strategy.

NHS providers must also determine the role that they are going to play, with local authority social service departments, in making their contribution to a range of comprehensive service developments for clients. The Health Act 1999 also demands that planning agreements should be reached between health and social service departments that identify clearly which services will be provided by each agency and which identify the processes to be adopted in assessing the needs of individuals in their care. The principle of effective alliance building between the NHS and social services has been further clarified by the role of workforce development directorates located within strategic health authorities in England. Such directorates outline requirements for health and social care services to work together to encourage the joint design, training and education of staff from both agencies in order to provide a workforce with the necessary capacity, skills and diversity to meet the needs of the local population. Alliance building is crucial if user needs are to be met within the context of an increasingly pluralistic health and social care economy, characterised by self-care and user choice and involvement.

The principles outlined in this chapter also require each government department to demonstrate emphasis on public health as a central concept within their business plan – a cornerstone of ‘joined up government’. For the health
service, charged with responsibility to enact national service frameworks and to produce integrated health improvement plans for local communities, a fundamental review is required to assess local public health capacity and capability, across sector boundaries.

In the future emphasis must also be placed on the promotion of health and alliance building between professionals and users of services. The focus of care is clearly placed within the community with an expectation that resources will be deployed to meet identified health and social care needs through the provision of integrated, peripatetic support from a range of professionals who will include doctors, community health care nurses, community specialist public health nurses, social workers, clinical psychologists, physiotherapists, speech therapists, radiographers and occupational therapists (supported by an efficient and appropriately funded intermediate/acute sector, inpatient service) (DH 2008d). The acute sector will complement the work of local primary health care workers who will continue to provide the first point of contact for clients and their families through the provision of effective intermediate and ambulatory treatment/assessment services. In turn, such services will be supported by the implementation of primary care-led emergency care walk-in centres, polyclinics and diagnostic and treatment centres, thus providing a range of ‘seamless’ assessment, diagnostic and treatment services for their local communities.

The next decade will therefore be characterised by the development of highly focused primary care services that will respond to the needs of local practice populations. In this model, much of the activity currently carried out by the local acute hospital will be transferred to general local primary services, some of them managed directly by local PCTs, others provided by independent or voluntary sector agencies. New polyclinics (DH 2007b) will also be introduced to provide an integrated, eclectic range of health and social care services, including diagnostic treatment services for the local population. Such local services will increasingly undertake minor and invasive surgery, routine diagnostic testing, support for cases requiring observation and most outpatient activity. Centralised or specialist hospital facilities will continue to deal with severely ill people with complex therapeutic needs and provide for major surgery. Older people and those with mental health needs or learning disabilities will also continue to be cared for (almost exclusively) in community care settings.

From a practical perspective the way in which primary care services will be delivered in the future will be determined from both national and local demand perspectives. Nationally key priorities are been determined annually by the DH and outlined in an operating framework document (see for example, the DH’s operating framework for the NHS in England for 2008/2009 (DH 2008b)). Examples of key operating targets include:

- Listening and responding to patients, the public and staff and improving patient outcomes and experience
- Moving towards local targets while delivering on national priorities
- Developing world-class commissioning as a key agent for change
- Sustaining a financial regime that supports service reform goals incentivises service improvement
- An emphasis on partnership working between PCTs, local authorities and other partners to ensure local health needs are better understood and addressed

Other priorities include the need for PCTs to:

- Empower patients, clients and carers and ensure more choice in service selection and treatment response; elicit objective feedback on ‘the patient experience’ and respond accordingly
- Tackle lifestyle issues, such as obesity and alcohol misuse
- Close the gap in life expectancy between affluent and deprived areas of the population
- Work closely with local authorities to provide integrated and co-located services, including joint commissioning
Redesign and implement care pathways that respond effectively to patient and service demand to support patients with longer-term conditions

- Reduce the rate of hospital acquired infection
- Management, leadership and clinical excellence in the workforce to enhance both capacity and capability
- Put in place and lead local information and management, and technology plans

A range of enabling strategies will also be put in place to support the implementation of these delivery plans including the empowerment of patients, the provision of choice, world-class commissioning capability and investment in workforce development, estate developments/hospital building programmes, leadership, education and training. Alongside these ‘enablers’ will be further investment in the development of more effective and responsive systems, information management and provider functions within the NHS (DH 2008a).

There is little doubt that the introduction of these new service delivery imperatives will provide the primary care nursing profession with a range of major challenges that must be addressed if the balance of care is to shift, according to government policy, to the community. One specific question must relate to the future education and training that will be required to equip practitioners with the necessary skills, knowledge and value base to be able to function effectively in the community. In reality, there is also likely to be a reallocation of tasks between nurses and others, including informal carers and other professionals (many of whom work currently in acute hospital settings and who will be required to transfer into new primary care settings as the context of care changes). Primary care nurses must therefore be prepared to develop and change, drawing on the very best of their past experience and becoming increasingly reliant on the production of research evidence to inform their future practice.

This section has proposed that the most effective way to meet the health needs of the local population is to focus primary health care services within the very heart of naturally occurring communities and neighbourhoods. In so doing (using the general practice population of the focus and locus for care) opportunities for the further improvement of multi-disciplinary teamwork and improved communication systems with clients (and others) will be provided. In order to transact effective care, the potential role that primary care nurses can undertake to fulfil the new NHS mandate must be acknowledged.

**The impact of primary care policy changes on the role of the primary care nurse**

In 2002, the DH published a major document entitled *Liberating the Talents*, which confirmed the role that primary care nurses are expected to play within the context of the, then ‘modernised’ health care service:

‘Nurses, midwives and health visitors are the largest group of professionals involved and will therefore have a significant impact on patient-led and community centred services. Like any profession their role cannot be described in isolation, and as the environment becomes more complex and uncertain, they will rely increasingly on a combination of developing their core skills (both general and specialist) and membership of multidisciplinary teams and networks. Their key attribute will be their ability to fit their skills with a wide range of others in a way that best meets the needs of the individual patient or group. They will play to the strengths of their professional role in integrating the medical and social aspects of health care, promoting self-care and crossing organisational boundaries to maximize continuity of patient care and health improvement.’

(Preface)

The essence of this statement has not changed. However, the policy drivers outlined in this chapter will have significant impact on the status of the primary care nurse as the ‘lynchpin’ within the context of a multi-disciplinary team of specialist health care practitioners. Their
work has also been directed by the advent of consumerism that has placed new demands for new competencies among the workforce with an emphasis on therapeutic skills, case management (this concept will be discussed later in this text), prescribing, clinical leadership and social enterprise skills. Further endorsement of the significance of the role that community and primary care nurses and health visitors will play within the reformed health services has been provided by the DH in the Next Stage Review of the NHS:

‘Community nurses, health visitors, allied health professionals and other staff working in our community health services are central to our vision for the future of primary and community care. The staff who work in these services speak with passion about the potential for using their professional skills to transform services. A dual focus on personal health care and community health lies at the heart of community services and underlies their key position in delivering high quality services and improving health outcomes.’

(DH 2008d, p. 4)

In summary, this will require that community and primary care nurses must be able to respond to the health needs, health gain requirements and expressed demands of their clients and local population groups so as to:

- Stimulate healthy lifestyles and self-care opportunities
- Design and deliver cost-effective and evidence-based treatment and care responses (including efficient and effective prescribing practice)
- Further educate families, informal carers, the community and other care workers
- Solve or assist in the solution of both individual and community health problems
- Orient their own as well as community efforts for health promotion and for the prevention of diseases, unnecessary suffering, disability and death
- Lead, work within, and with inter-professional teams, and participate in the development and leadership of such teams

- Participate in the enhancement and delivery of primary health care in a multi-disciplinary care context
- Co-design and co-deliver innovative and responsive packages of care in partnership with service users and their carers (particularly in the effective management of longer-term conditions)
- Contribute to the effective commissioning of new services that are designed to meet the needs of the local population
- Create the requisite conditions to provide entrepreneurial services that respond to the actual needs of local service users and commissioners

Finally, in this section, the importance of public health is emphasised. (Nursing and Midwifery Council [NMC] 2004, p. 1). While it is postulated that public health is a key role for all primary health care nurses, it is of course a fundamental role for specialist community public health nurses. Such practitioners are normally engaged in:

- Monitoring and profiling the health of their community/practice area
- Ensuring that public health issues are identified and reported to managers and commissioners
- Monitoring health outcomes of their interventions
- Improving the effectiveness of their activities
- Developing local health strategies and building healthy alliances necessary to implement these
- Developing and maintaining partnerships with clients, informal carers, other community members, and other professionals
- Collaborating with local authorities and other agencies to monitor and control health-related issues considered to be hazardous to the well-being of the community
- Informing the public about public health issues; engaging in health promotion programmes
- Ensuring that members of the community have access to appropriate public health advice
The scope of primary care nursing practice within the context of a changing workforce

One key enabler of the proposed health care reforms will be the workforce and its ability to prepare itself for the new world of work, characterised by inter-professional teamwork and intersectoral care practice that follows the ‘patient experience’ (e.g. transitional care provision between the acute and primary care sectors). Flexible and adaptable career (and associated educational) pathways will be needed to support the new workforce once they are registered (DH 2006). One key example relates to the need to provide flexible career progression opportunities to enable nurses and allied health professional staff to move seamlessly between acute and primary care service settings and to reduce dependency on the actual care setting itself. Flexibility will also be needed to encourage staff to move between employers and between the health care, social care and voluntary/independent care sectors.

Current government policy provides considerable opportunities for the development of innovative care solutions within which nurses, often in partnership with social workers and other support staff, will be able to provide responsive services to clients in response to their identified needs. As agency boundaries break down between primary, intermediate, secondary and tertiary care sectors, and professional skills transcend previously defended frontiers, service users will have freer access to nursing skills. The way in which access is negotiated for nursing skills will, in the future, be through single case assessment and case management or contractual processes, which should make nursing skills more easily accessible to the general practice population. Their understanding (often acquired from many years of experience and proven competence in the delivery of care to their clients) has placed primary care nurses (and those acute sector nurses who are intending to transfer to the community) in an ideal position within the ‘reformed’ NHS to respond more flexibly to locally identified health and social care-related needs.

These principles were set down earlier by the Department of Health in a consultation paper entitled A Health Service of All the Talents: Developing the NHS Workforce (DH 2000b). The paper noted the need for ‘transformation’ within the NHS workforce in order to ensure that it was ‘fit for purpose’ in delivering the proposed health care agenda. The paper confirmed that emphasis should be placed on:

- Team working across professional and organisational boundaries
- Flexible working to make best use of the range of skills and knowledge that staff possess
- Streamlined workforce planning and development which stems from the needs of patients, not professionals
- Maximising the contribution of all staff to patient care, doing away with barriers that say only doctors or nurses can provide particular types of care
- Modernising education and training to ensure staff are equipped with the skills they need to work in a complex, changing NHS
- Developing new, more flexible, careers for staff of all professions and grades
- Expanding the workforce to meet future demands

These principles continue to remain relevant as we reach the end of the current decade. However, the consequence of such proposals for many primary care nurses has required them to engage in lifelong learning with the aim of continuously seeking to enhance their skills and knowledge in accordance with evidence-based practice for the benefit of their clients and patients. In addition, new flexible roles and responsibilities will demand that primary care nurses seek to validate their skills and practices through the process of peer review and to share learning/education with other professionals. Increased emphasis will also be placed on competence-based education and in the acquisition of enhanced skills in clinical leadership and commissioning.

In order to respond to the demands of the new flexible workforce, primary care services will need to create, implement, share...
and explore key issues in relation to the local distribution, sustainability and transferability of innovative ‘new role’ solutions in primary and intermediate care in order to inform the competencies, practice, education and learning requirements of such new roles (DH 2008d). This will include:

- Agreeing actions arising from local and national discussion relating to the key practice, education/training and regulation issues that need to be addressed to enable sustainability, and spread of new ‘fit for purpose’ primary care practitioners whose roles are designed to meet the demands of evolving and complex inter-professional health and social care work streams.

- Ensuring that universities and their associated partner trusts/social service departments, engage in the design and implementation of new education programmes that are informed by the standards of practice that will be identified through the national changing workforce programmes and other ‘modernisation’ imperatives.

- Agreeing a framework for the development of competencies and associated regulation for new emergent roles in order to maximise opportunities for new ways of working within the NHS career framework.

- Undertaking operational research and evaluation that is designed to measure the effectiveness and impact of such new roles and competencies.

If these aims are to be achieved then there is a need to ensure that the primary, social and intermediate care workforce is not developed in isolation, but set within the context of national and local workforce requirements, supported by education frameworks developed in partnership with local practitioners. A new workforce will also need to be prepared to meet the diverse needs of the new emergent polyclinics, underpinned by a new cadre of advanced practitioners (NMC 2007), who will be able to assess, diagnose, treat patients and prescribe. Additionally new associate, or assistant practitioner, roles will emerge to enhance the skill base of the support worker workforce. Such ‘new ways of working’ have highlighted the challenges that the introduction of new roles present to employees, employers, regulators and educationalists. One key lesson learned to date is that new roles must be well defined and underpinned by competence-based role descriptions, accompanied by customised educational programmes and supervisory arrangements. The programmes of education that will be required to support the emergent primary care workforce should reflect/include:

- Diversity to provide flexible entry and progression points for new roles
- Co-designing and co-delivering programmes in partnership with users and carers.
- Career/competence development within the context of Agenda for Change (DH 2003a), and competence mapping against the NHS Knowledge and Skills Framework
- Design and delivery of comprehensive educational packages to ensure coherent implementation of changing workforce requirements, e.g. The provision of professional development programmes for nurses undertaking specialist roles such as public health, heart failure/chronic obstructive pulmonary disease, reducing readmission, commissioning, social enterprise, case management, clinical leadership, etc.
- Development of key leadership skills in primary care-led services
- Embedding and mainstreaming new roles and new ways of working for a range of practitioners from assistant to advanced practitioners
- Designing innovative work-based practice assessment methods to ensure staff are ‘fit for purpose’ and safe and effective practitioners (thereby affording public protection)
- Design of e-based virtual learning environments/distance learning through the use of innovative learning and teaching methodologies
- Development of shared learning with GPs, social workers and other members of the health care team (including intermediate care professionals)
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- Determining, ‘piloting’ and evaluating a range of new competencies for such new roles
- Development and implementation of a defined ‘role map’ for a new inter-professional and multi-agency workforce
- Ensuring that the introduction of these new roles is underpinned by short-, medium- and long-term strategic plans in order to ensure flexibility, transferability and sustainability, and to encourage recruitment and retention of staff working in these new evolving roles
- Recognition of key policy drivers impacting on service provision (particularly in relation to the management of longer-term conditions, integrated case assessment, care/case management, unscheduled emergency care/ out of hours provision and specialist care provision), which require expediency in the introduction of these roles
- Ensuring that local PCT delivery plans facilitate the ability to change workforce profiles; current and future workforce profiles should focus on matching local need with national policy
- Provision of flexible commissioning arrangements for education programmes in and across strategic health/social care economies
- Supporting effective educational provision through the creation of ‘fit for purpose’ learning/knowledge transfer environments in primary care service settings
- Celebrating, recognising and disseminating excellence in service design and delivery

In addition proficient primary care practitioners will need to ensure the following.

- They provide essential services to their local communities. These services are needed by a range of care groups with differing needs delivered in a variety of settings. Whatever the title, employer or setting, there are, among others, core functions that staff will need to provide: first contact, expert continuing care and the delivery of effective prevention/public health programmes.
- Their services are based on robust assessment of needs of individuals and populations and the skills required to meet those needs. These functions should be provided across all age and social groups according to need and designed around the journey that the patient/client takes. In order to safeguard vulnerable people the local population requires high-quality generalist as well as specialist service responses.
- Patients, clients, carers and communities are involved actively in service changes and provided with greater choice – services will therefore need to respond to the people who use and fund them.
- A significant number of primary care practitioners are supported to assume advanced and specialist roles across a range of core functions, but in particular to:
  - Improve access to general practice services, as the role of nurses in assessing and managing conditions (previously seen to be the remit of GPs) is increasingly recognised
  - Provide more secondary care in the community (including care of people with longer-term conditions, ambulatory and palliative care needs)
  - Lead and deliver priority public health interventions
  - Acquire and apply expert skills in clinical leadership, informed by a thorough understanding of service commissioning.
- They engage in partnership with the wider health and social care team. As such there will be more generic working with practitioners working across settings, providing a wider range of care to individuals, families and communities. Support workers and qualified staff will become more integrated within the primary/social care workforce.
- They will be more understanding of the commonality of roles across health and social care and hospitals and primary/community care, with more joint posts and less anxiety about protecting professional roles when responding to patient and community needs.
- Frontline practitioners have greater freedom to innovate and make decisions about
services and the care that they provide. This will need to be matched with greater accountability for individual professional judgement and the use of best available evidence to inform their practice.

- Effective leadership is evidenced if our services are to take on new roles, work differently and deliver the NHS plan improvements for patients, clients and communities. This will demand greater understanding of team development and the management capability to use human and financial resources creatively and to assess and manage risks accordingly within the parameters of ‘safe practice’.

The workforce of the future will also prepare and deploy a range of competent assistant practitioners who will work in direct support of the professionally qualified primary care team. New roles are now emerging to support assistant practitioners to acquire a range of competencies that have been designed to enable them to respond to the needs of the local health/social care economy. Such roles interface with the development and implementation of new foundation degree programmes, informed by key health and social care imperatives including Agenda for Change (DH 2003a), and the Knowledge and Skills Framework (DH 2003b), and new emergent educational models supported and endorsed by the NHS.

As the scope of primary health care widens, opportunities for appropriately skilled and experienced primary care nurses to develop as advanced practitioners and nurse consultants will be provided. The challenge for the nurses themselves must be for them to articulate their skills, advance their practice (underpinned by evidence-based enquiry skills) and to market their contribution effectively to both their clients/patients and to commissioners of health/social care services.

New practice developments must therefore emerge to fulfil patient and provider agency expectations as increasingly complex care packages are transferred from the acute hospital sector to primary health care services and their associated provider services (DH 2008c). In order to ensure that nurses provide effective care to their clients, practitioners must ensure that they are effectively supervised in all areas of their practice and ‘keep in touch’ with the aims and objectives of their clients and senior managers. There are many ways to achieve this objective but perhaps the most successful has been the provision of clinical supervision and positive feedback from line managers. Clinical supervision has been recommended in various forms by the NMC for all of its nurses with the aim of providing staff with a framework within which to receive positive feedback on their performance and to share their own perceptions of how effective they consider their contribution to client care to be (NMC 2008).

The main professional challenges for primary care nurses may be summarised as the need to:

- Maintain and develop specialist/advanced diagnostic, clinical/therapeutic skills and competence
- Expand their knowledge and skills and to act on research-based best evidence to enhance their practice
- Recognise and accept personal accountability for nursing actions
- Pursue continuing professional education to enhance competence and patient safety
- Market skills to an increasingly diverse range of health and social care commissioners
- Promote public health/protection and assist in the development and maintenance of ‘healthy communities’
- Engage in effective clinical supervision
- Exercise strategic leadership skills
- Constantly evaluate personal and collective performance

International influences on the health care agenda

The organisation of health care delivery and nursing activity in the UK is also influenced by a number of international agreements and agendas that are negotiated within the World Health Organization (WHO) and within the European Community (EC).
For example, the public health chapter of the EC Treaty of Economic Union (European Parliament Committee Report on the Environment [The Maastricht Treaty] 1993), requires all European countries to contribute to the promotion of health awareness and health protection by encouraging the design and implementation of local health initiatives and community health programmes. Such activities are directed towards action that prevents the incidence of major diseases, including drug dependence, by promoting research into their causes and means of transmission, as well as health information and education. Health has also been afforded enhanced status as a standing item on the European Parliament agenda in Brussels. Article 153 of the Treaty of Amsterdam 1999, commits the EU to achieving ‘a high level of human health protection’.

European influences also regulate the movement of nurses between member states; systems and directives have also been agreed to enable European countries to ascribe mutual recognition to their pre-qualifying systems of nurse education. These systems have been designed to facilitate mutual harmonisation and recognition between countries in the EC and provide a shared framework for the preparation of nurse specialists throughout the region.

Within the wider context, the WHO also sets targets for health gain and health promotion. For example, in 1987, WHO published targets with the aim of improving the quality of health care delivery and surveillance for all world citizens. These targets have assisted in shaping the health care agenda in the UK and have facilitated the introduction of common standards for primary health services throughout the world. Other policy matters relate to the design of global health and nursing strategies based on the following principles:

- Equity – thus reducing the existence of inequalities between countries and within countries
- Health promotion – providing for the development of personal self-reliance and the acquisition of a positive sense of health
- Participation – requiring the active participation of world citizens in informing themselves (and others) about health matters
- Multi-sectoral cooperation – promoting international agreements on health targets, polices and strategies
- Primary health care – focusing attention on the importance of primary care delivery as the health care system closest to where clients live and work
- International cooperation – recognising that health problems cross international frontiers, e.g. pollution

**Conclusion**

This chapter has proposed that the ‘reformed’ health service requires a workforce that is both fit for practice and fit for purpose, equipped with competencies that will enable practitioners to function across a range of priority, inter-professional care pathways both within hospital and within primary care settings (including new polyclinics). In designing the new workforce we should be cognisant of the demand placed by service commissioners and providers to ensure flexibility within the workforce to accommodate to emergent needs in the population (DH 2008c,d).

The chapter has recognised that the demand for health care, influenced by changes in disease pattern and treatment response will evolve, based primarily on the co-delivery of health care in partnership between users, carers and clinicians. The NHS ‘choice’ agenda with emphasis being placed on home-based care in the community, has been a key driver for the government’s vision of primary care services, which has been characterised with concepts relating to new sources of patient engagement, care packages for treatment and access arrangements to a multiplicity of care providers.

The reformed health agenda in England has been further influenced by the government’s commissioned review of health care provision undertaken by Professor Lord Ara Darzi (DH 2008a,c,d). In his final report, *High Quality Care for All: NHS Next Stage Review*, a new vision for an empowered workforce, equipped with requisite
skills and competencies is outlined. Key tenets for health care reform and new models of care delivery are expounded, impacting specifically within the community and its associated primary and social care services.

On the supply side we have noted the emergence of an increasingly diverse range of providers, including the role of the voluntary or ‘third sector’ and reliance on the commercial sector to provide substantial elements of diagnostic and treatment provision in the UK. Information technology has also made significant advances, which, in the next five years, will impact even further on patient care outcomes and service delivery. This will empower and inform patients and enable them to engage more effectively in judging health care performance and in assuming responsibility for personalised health care.

The importance of providing a competent workforce that is prepared to confront challenges relating to inequalities in health and social care treatment responses are also understood, as are the significant requirements for adherence to professional regulatory standards. Standards of proficiency, the enhancement of clinical skill competence and leadership, and the acquisition of clinical judgement skills in decision-making and care planning have also been identified as key drivers for change in care practice.

The key policy directives that have shaped our reformed health service in recent years have been derived from The NHS Plan of 2000, which has been updated significantly on an annual basis by our government health departments. For example, greater recognition has been given to supporting people with longer-term conditions, which was outlined in the DH health document (2005): Supporting People with Long Term Conditions – Liberating the Talents for Nurses Who Care for People with Long Term Conditions. Similarly this text has taken full account of emergent themes and trends from the DH’s announcement (2006a) on modernising nursing careers (www.dh.gov.uk/cno).

More specifically, the Chief Nursing Officer’s review of mental health nursing (2006c) and Ruth Northway’s review of future directions for learning disability nursing (Northway et al. 2006) have been used to inform relevant chapters in this new edition. Nurses continue to be central to government plans as identified in DH’s (2006a) Modernising Nursing Careers. For example, nurses play key roles in establishing new models of primary care and social enterprise and are integral to developing care pathways as part of the multi-disciplinary team. Following the successful implementation of national service frameworks, programmes of care policy have progressed to produce national competence standards identified by Skills for Health, which in turn inform educational curricula for primary care practitioners.

In summary the health service has engaged in a period of self-reflection and re-examination of personal and public values, thus reinforcing the need for clients to assume personal responsibility for their own social and health care needs. The reduction in dependency on inpatient care in our hospitals has assisted in the transfer of care to the community and to our naturally occurring neighbourhood support systems. Care in the community and investment in public health/primary care strategies will become an increasing feature of our health care philosophy and, in partnership with a rationalised (and smaller) acute sector, will provide the context for our health care system for the foreseeable future.

The significant role that the primary care trusts, strategic health authorities and social service departments play, further reinforces the government’s commitment to primary care and the transformation of services. Lord Darzi in his vision for primary and community care, for example, advised that:

‘Community services are in a central position to delivery the Next Stage Review of the NHS, and of critical importance in delivering our vision for the future of primary and community care… Increased influence for community staff in service transformation, through a commitment
to multi-professional engagement in practice based commissioning and the piloting of more integrated clinical collaborations.’

(DH 2008d, p. 1)

If this vision is to be achieved than the importance of leadership for primary care nursing must be acknowledged and responsive systems put in place to facilitate the emergence of innovative practice in local practice settings. Nurses must also continue to advocate for their clients, families and communities and engage in raising health-related issues for inclusion in local and government policy agendas. Above all they must demonstrate confidence and competence to assess risks and to practise safely in accordance with their professional code of practice (NMC 2008). Our primary care practitioners need to be prepared to respond to an increasingly well-informed public that is keen to have a bigger say in their care and treatment. The overall thrust of this new edition has been to re-focus and reform our understanding of primary care practice within the context of a rapidly evolving health service.

References

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