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Primary care nursing: education for changing roles and boundaries

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The primary care landscape continues to be redrawn, driven by the modernisation agenda in general practice, public health policies, national care standards and the movement to involve the public and patients in service design and delivery.[1,2] In this paper we discuss how primary care nursing is developing within the context of these changes and the implications for education. Our account does not pretend to be comprehensive; rather it draws on our own backgrounds of practice, teaching and research in gerontological, public and sexual health nursing in primary care, with illustrations from chronic disease management, public health and public/patient involvement. We recognise the importance of work that primary care nurses do in teams to deliver high-quality services and see this as a cross-cutting theme in changing roles. Although we raise some old questions, our answers are framed in terms of how a future primary care workforce can best be prepared and supported in order to deal with the clinical, interprofessional and organisational challenges of existing and future primary care models.

INTRODUCTION

The primary care nursing workforce represents 17% of the nurses, midwives and health visitors employed in the NHS in England. In 2002 there were 49 651 whole-time equivalent nurses and health visitors working in primary care.[3,4] Although the practice nurse and registered nurse workforce has grown throughout the 1990s, there has been little overall change in the numbers of district nurses and health visitors.[5] It is the latter groups that have a significantly higher age profile, with nearly half of current staff set to retire over the next ten years.[4] In the light of these projections of a dwindling and ageing workforce, and the increased demands for capacity and requirements for enhanced clinical and psychosocial skills in nursing, it is not surprising that the 19th-century model of district nursing and health visiting is being challenged.

HOW IS PRIMARY CARE NURSING CHANGING?

The role and allocation of tasks between primary care nurses are changing rapidly as existing teams and working practices are redesigned to meet the targets of the new General Medical Services (GMS) contract and the NHS modernisation agenda.[6] The traditional model of the health visitor's domain in public health and the district nurse's role in providing nursing care and support of older people in their own homes will provide a backbone of specialist expertise to primary care.[7] However, given the capacity problems alluded to earlier, this cannot be the only model. Over the next few years in primary care trusts (PCTs) there will be additional opportunities for newly qualified nurses, experienced registered nurses, specialist nurses and community matrons to contribute to an expanding mix of skills within the nursing team.[6] It is likely that there will be a mixed economy of employers, and the independent sector will provide care services in tandem with primary care services. Further shifts in role are likely to come with increased expectations that patients have for appropriate and timely interventions; and friendly services that involve people in decision making and that communicate with other parts of the system.[8,9]

The domains of nursing and health visiting in primary care are outlined in Box 1, showing how they are now being reconfigured around the following three key themes by the current emphasis in government policy.

1 First contact/acute assessment, diagnosis, care treatment and referral.
2 Continuing care, rehabilitation, chronic disease management and delivering National Service Frameworks (NSFs).[10]
3 Public health/health protection and promotion programmes that improve health and reduce inequalities.[6]

We discuss these themes in relation to the role of nurses in chronic disease management, public health and patient and public involvement in primary care, and raise questions for the educational preparation and support for developing and changing roles. We understand the term primary care nursing to be inclusive of health visiting, school nursing, district nursing, practice nursing and other specialist groups, although this paper focuses mainly on the roles of district and practice nurses.

NURSING ROLES IN CHRONIC DISEASE MANAGEMENT

There are 17.5 million adults living with chronic disease, and most of these are people aged 75 years and over, who receive support and treatment from health- and social care.[11] Community nursing has a long-established if low profile in chronic disease management. For example, district nurses prescribing a range of medications, teaching patients and their carers to manage insulin administration, recommending aids and adaptations and coping strategies to patients with rheu-

Box 1 The domains of primary care nursing and the current policy emphasis

Domains of primary care nursing[12]

- Available 24 hours a day, 365 days a year
- Works in partnership with and supportive of individuals through change and major life events
- Establishes close relationships with clients and carers
- Knowledge of the local environment and social context
- Provides care for sick people in their own homes
- Ambulatory and domiciliary health promotion and the management of chronic disease
- Provides a link between agencies and professionals
- Identifies and manages risk of vulnerable clients

Emphasis in government policy[6]

- Key role in developing 24-hour first-contact care across a range of settings
- Greater voice in decision making
- A service where patients and public have greater voice and greater choice
- Opportunities to provide more secondary care in community settings
- Extending nursing roles, including some work currently done by GPs
- Major role in developing NSFs
- Focus on prevention and tackling inequalities
- Greater skill mix and leadership opportunities

matoid arthritis, as well as the practice nurses' role in managing coronary heart disease risk by providing advice to patients about exercise, stress reduction and diet.

The NHS improvement agenda sets out policies for developing chronic disease management using nurse-led case management systems. This is drawing on the experience of health maintenance organisations in the United States, for example Kaiser Permanente (North California) and Group Health (Washington State), which have implemented successful models of nurse-led disease management. These systems have had a measurable impact on reducing costs, admissions to hospital and long-term care in the US. There are a number of models operating with different US populations, and the general approach has been summarised by Dixon *et al* as:

- mobilising community resources to meet the needs of patients
- cultural change in healthcare organisations [sic] from reactive to proactive models of care
- promoting self-management and the expert patient model
- designing delivery systems that encompass assessment, case management, interprofessional and collaborative processes, as well as review
- evidence-based clinical pathways
- clinical information systems.[13]

There is some evidence to suggest that nurse-led chronic disease management is effective. For example, a meta-analysis of trials of intensive nurse home-visiting support programmes of a general population of older people demonstrates a relationship with reductions in admissions to long-term care, but no significant

reduction in hospital admissions or improvement in functional status.[14] Nurses may also facilitate the expert patient model and the role of lay leaders in positively developing patient self-management skills in arthritis, specifically in relation to coping, functional ability, and use of hospital services.[15–17] Furthermore, there is growing evidence from the US that team-based interventions in chronic disease are associated with better patient outcomes – the involvement of nurses in assessment, treatment, self-management support and follow-up has been linked to improved professional adherence to guidelines, patient satisfaction, clinical and health status, and use of health services.[18] Given the latter, it appears likely that there is going to be an expansion in opportunities for nurse-led case management to provide interventions, working for a range of providers, and to co-ordinate the care and support so that people with chronic illness and long-term problems can stay at home and avoid hospital admission. These complex roles will require knowledge of a range of chronic disease trajectories, psychosocial interventions and advanced clinical interventions, as well as teamwork skills. In order to develop and support these there will be a need for tailored modular postgraduate interprofessional education programmes, with advanced skills development for implementation in both health- and social care.

NURSING ROLES IN PUBLIC HEALTH

The idea of chronic disease management recalls Caplan's 1961 classification of primary, secondary and tertiary health promotion and prevention, all of which involve primary and community care nurses, to a greater or lesser extent, undertaking some element of role development within their existing professional boundaries.[19] Primary prevention entails intervention to prevent the incidence of disease, for example by immunisation. Secondary prevention involves the early detection of illness using tested screening techniques – for instance, measuring blood pressure; testing the urine for glucose; or chlamydia screening in general practice or adolescent sexual health services.[20] Testing may take place routinely at first contact or if a clinical problem is suspected. Primary care and community nurses increasingly participate in multidisciplinary screening programmes. In addition to undertaking technical procedures, such as venepuncture for haemoglobin levels, sight testing and electrocardiographs, nurses may be involved in promoting health advice on diet, exercise and leisure activities. This means that GP-employed nurses must have an operational understanding of epidemiology in terms of developing disease registers, changing disease patterns and local demographic profiles of their practice's registered list of patients. Tertiary prevention is defined as the measures taken to alleviate an existing condition, prevent complications and modulate the effects of illness. The community nurse may deploy a tertiary preventive approach in several ways, for example by:

- implementing a home-based rehabilitation programme for the aftercare of a person who has experienced stroke, helping with adjustment to disability and preventing complications

- identifying the risk of falls in partnership with older people, and disseminating awareness of safety measures to prevent accidents and falls caused by unsuitable footwear, torn floor coverings and unlit passages
- increasing older people's awareness about environmental problems that may cause ill health, such as the risks of hypothermia, the problems of muscle wastage caused by immobility, and depression and constipation owing to a low roughage diet and insufficient exercise
- teaching carers how to prevent pressure sores, and demonstrating the principles of safe lifting and handling to ensure comfort to the carer and prevent damage to patients' skin tissues.

The above examples imply significant development issues and challenges for primary care nursing roles and education. The provision of health promotion, such as a falls exercise class, may take place in the home setting at an individual level with the patient/carer or in a group setting in a health centre, community centre, day centre or residential home. Across differing service configurations, it may be a community nurse, an occupational therapist, a physiotherapist or a lay leader (or a combination of the latter) who is competent and available to provide such interventions. Some evidence does suggest that interprofessional interventions that embody active roles for carers (alongside those of health- and social care professionals) require some degree of educational preparation so that participants can work alongside each other with mutually shared goals.[21] However, it is the community nurse who occupies a traditionally unique position as the accepted visitor to the home setting, with a professional remit for facilitating access to health- and social care resources. In addition s/he may well have become a well-known and trusted figure over time and so may be in a position to support, influence and/or change patients' pre-existing health-related attitudes and/or behaviours. One key challenge for the commissioning of post-registration education and training is to continue developing clinically relevant and accessible programmes of undergraduate and postgraduate education and training to underpin these sorts of preventive interventions,[22] for example, the remotely accessed open/distance learning modular programmes and the more local and onsite continuing professional development (CPD) modular programmes commissioned via workforce development confederations (WDCs).[23–25]

PATIENT AND PUBLIC INVOLVEMENT

One of the many challenges facing primary care organisations is how to offer more choice and to address and realise the opportunities for patients, carers and communities to shape local healthcare services.[26] Since the 1990s rapid policy development has steered the NHS towards recognising and responding to the needs of its 'customers'.[27–29] This is a complex area, with a rapidly expanding literature and a growing understanding of the tensions that arise in trying to achieve change at different levels in health- and social care.[30] Biggs points out the inherent inequalities that exist between users and professionals that limit

genuine possibilities of choice and participation.[31] He identifies these as different interests, priorities and cultural concerns, as well as effective exclusion from the negotiating arena of commissioning. In primary and social care the issue of involvement is complex because of the diversity of generalist and specialist services, the uncertainty and long-term nature of many care pathways and its perceived difficult and time-consuming nature, together with the inconsistent use of terms for 'service user', 'patient', 'public', 'consumer' and 'lay person'.[32] A recent study of six primary care organisations in London showed that effective strategies to involve patients and local communities rarely follow any single model.[33] This perhaps reflects the importance of taking into account variation in context and priorities of different and minority groups. For nurses, as for other professionals, there are practical issues, such as remuneration for users' time, and training for professionals to be able to support service user involvement.[34] The aim is to develop meaningful partnerships, rather than just expounding user involvement/patient participation as an 'article of faith'.[35] Education, training and development of nurses and other professionals to collaborate with service users in clinical decision making, service design and delivery/evaluation of those services are important tasks that need to be undertaken on a number of levels from initial preparation through existing and new CPD programmes.

IMPLICATIONS FOR PRIMARY CARE NURSE EDUCATION

What do these changes and developments in the delivery of nursing care and community participation mean for the way in which nurses should be prepared and supported? The demands for new and modernised services in primary care require flexible and skilled professionals working at a range of levels. Recent thinking officially acknowledges the changing levels of nursing practice by designating titles for the differing roles of primary, advanced and advanced-specialist practitioners.[6,25] In these newly proposed frameworks, the future development of nursing practice is seen as dependent on differing levels of professional competency underpinned by appropriately commissioned education provision, up to and including masters and doctoral level.[25] For the newly qualified, it is recommended that employers provide a period of preceptorship linked to development programmes, with employers facilitating learning opportunities to underpin professional development.[25] Building on this first point, it is clear that PCTs, as both education commissioners and employers, will be challenged in various ways in relation to facilitating many of these opportunities for those they directly employ or those from whom they commission services, such as GPs. Particular difficulties may arise for developing such opportunities within the general practice setting, where a dearth of workforce data exists and where access to education provision has historically been more complex, due to GPs' independent contractor status.[4,36,37]

The development of new recruitment/retention initiatives to foster flexible career routes is also something that needs to be evaluated.[4] One national study of recruitment/retention initiatives in the primary care nursing workforce in

England has already recommended that strategic health authorities (SHAs)/ WDCs (in partnership with PCTs and higher education institutions) develop programmes for nurses around the three key themes in *Liberating the Talents* (see Box 1), and review the available specialist practitioner programmes for primary care nurses in light of changing workforce and role profiles.[6] For some this may mean increased commissioning of nurse practitioner and community matron roles in order to meet the primary care modernisation agenda. A danger exists if such moves negatively impact upon the future skill mix of the district nursing/intermediate care workforce by cherry-picking key elements of that particular workforce which undertakes the majority of community care for older people.[7] If that happens, generalist services may be further denuded, as was perceived to be the effect of NHS Direct on the accident and emergency nursing workforce. Given the locally negotiated terms and conditions of many GP-employed nurses, the differing priorities of GP employers, coupled with their differing human resources management practices, could further negatively impact on recruitment/retention practices and complicate access to education provision for GP-employed nurses.[4,37] Some SHAs appear already to understand the complexity of these relationships and have put in place developments for identifying the local inter-relationships between terms/conditions of service and grading, as well as models of professional accountability for general practice-employed nurses.[36,38]

If nursing is to truly engage in partnership opportunities to develop initiatives in primary care, for example as case managers of chronic disease pathways, as ‘entrepreneurs’ with the independent sector and in community participation and local regeneration, then commissioned education provision for primary care nursing must be congruent with evidence-based policy. At present, some local and national evidence indicates that CPD opportunities for GP-employed nurses are still overly complicated by the nature of the CPD commissioning process and the differing employment contexts for nurses in primary care.[4,36] The latter span NHS terms/conditions as well as GPs’ independent contractor status. When they are viewed alongside the changing demographics in community nursing discussed above, it is clear that what is now required is a much broader vision for developing the primary care nursing workforce in order to underpin current service provision and future needs.[6,25] However, who pays for this, and how it can be realised, are some of the pressing issues that PCTs and SHAs/WDCs will continue to address.

CONCLUSION

In conclusion, it is likely that in the near future there will emerge differing models of primary care service delivery. These may vary from integrated health- and social care services to GP-led delivery (with independent providers in specialist areas), together with nurse-led entrepreneurial models and mixtures of all of these models. Our own view is that primary care nurses need to be prepared with transferable skills that embrace teamwork, communication/interpersonal skills, as well as change management and leadership skills in order to work flexibly

within whatever model (or mix of models) may predominate locally. Whilst this should not compromise the maintenance and enhancement of essential clinical assessment, skilled interventions and provision of nursing care/support, we argue that within this newly emerging workforce it is access to both formal and informal modes of learning that is required. The latter should include greater creative commissioning for the development of learning sets, team learning in practice, and the development of rotational roles linking between practice, education and research. This would aim to have the dual effect of enhancing workforce retention across the nursing skill mix in different sectors, whilst further developing nurses' individual clinical, education and research skills.

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