1 Emergence of the advanced primary care nurse

Rebecca Neno, Lucy Botting and Marcus Neno

Introduction

The emergence of the advanced primary care nurse practitioner has been slow in comparison to their emergence and significance within the United States of America. This, in part, has been influenced by the development of nursing as a profession within the United Kingdom and also the structure of the National Health Service. This chapter will chart the development of nursing as a profession and the development of primary care nursing from its roots to the present day. The chapter will identify the origins of advanced nurse practitioners within the United States of America and how they developed as an autonomous professional group within the United Kingdom. Alongside this, relevant policy developments will also be discussed and the opportunities created for advanced primary care nurses identified with suggestions for developments in the future highlighted and explored.

Early nursing developments

The development of care in the community and community nursing have separate histories but both have had an impact on the way in which primary care nursing is delivered and practised today. The origins of the community care debate started with the Mental Health Act 1959, which was concerned with those with mental health issues and those with learning disabilities who had previously been kept away from the community in institutions. In comparison, community care of the physically sick has a longer history that has its origins in a number of places. These were mainly informal arrangements beginning with the priest St Vincent DePaul (1580–1660). He not only undertook the task of caring from the poor, but encouraged his parishioners to do the same by organising them and defining their roles after they had visited a home (Allan and Jolley, 1982).

In 1840 the Deaconesses’ movement of the Kaiserwerth pioneered the
building of a hospital under the direction of Theodor and Frederick Fliedner. This had a perpetuating effect, which resulted in the setting up of numerous other hospitals and the extension of the service of caring for the sick in their own homes.

In the 19th century, Poor Law committees undertook the task of employing parish nurses to care for sick people in their own homes. This was seen as cheaper than transferring them to the workhouses. Those who were not classed as paupers were cared for by visiting charities and, in 1840, Elizabeth Fry set up an institution based on the concepts of the Deaconesses’ movement of the Kaiserwerth. The aim was to introduce women of the upper classes to training to care for their own sick (Watson, 2001). The success of this venture was limited by poor structure and unclear goals (Fraser, 1980).

The first primary care nurses

Some years earlier, in 1859, William Rathbone, a Liverpool merchant, philanthropist and later an MP, had employed a nurse, Mary Robinson, to nurse his wife at home during her final illness. After his wife’s death, he retained Mary Robinson’s services so that people in Liverpool who could not afford to pay for nursing would benefit from care in their own homes. Seeing the good that nursing in the home could do, William Rathbone and Florence Nightingale worked together to develop the service. When too few trained nurses could be found, Rathbone set up and funded a nursing school in Liverpool specifically to train nurses for the 18 ‘districts’ of the city and so organised ‘district nursing’ began.

The late 19th and early 20th centuries saw major and rapid changes taking place in the developments within health and social care (Watson, 2001). Midwives were regulated in 1902 and the notification of births became compulsory and the National Insurance Act was launched in 1911. By the time the NHS was launched in 1948 other health professionals such as school nurses had been introduced into some authorities.

Health visiting developed out of the UK public health movement of the late 19th century (Dingwall, 1977). Although the Health Visitors’ Association was founded in 1896, originally known as the Women’s Sanitary Inspectors Association, it was not until 1915 that the government formally created the position of the health visitor. However, the idea can be traced back to Florence Nightingale, who worked to raise awareness of the effects that poor sanitation can have on health. As a result of concerns over the high infant mortality rate in east London, a health visiting service was established in 1907. The child death rate halved in Ilford, London, during 1910–1912 following the appointment of the first health visitor in the area. During this time health visitors primarily provided information and focused on hygiene
awareness, such as teaching mothers to clean feeding equipment. Health visiting was accountable to medical officers of health until 1974 and did not become an exclusive nursing speciality until 1962 (Robinson, 1982).

From 1919 when state registration for nurses became a reality, although the national standard fluctuated, at least it was possible to differentiate between trained and untrained nurses and General Nursing Council registration became a prerequisite for starting courses such as district nursing and health visiting. Eventually, in 1981, the specialist practitioner qualification was introduced and the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) required the recording of the qualification on the nursing, midwifery and health visiting register. This qualification is still offered today but there is an increasing trend of fewer places available and a decline in applications, despite the continued investment within primary care services. The future of the specialist practitioner award should be addressed in the current review of post-registration education conducted by the Department of Health (see Chapter 15 for further information).

Reviews of primary care nursing

The Cumberlege Report (DHSS, 1986) on neighbourhood nursing, was the first report to recommend far-reaching reforms of community nursing services and health needs were considered to be inclusive of the following five key areas:

1. older people
2. disabled people
3. the chronically sick
4. the terminally ill
5. preventive care.

Today these five key areas have seen considerable improvements, for example the publication of the National Service Framework for Older People (DH, 2001), the End of Life Care Programme led by the Department of Health (2003), the enhanced focus on public health and health promotion (DH, 2004a) and the recent increased emphasis on the management of long-term illness conditions (DH, 2005a).

The publication of the NHS and Community Care Act in 1990 identified a much clearer understanding of how the government wanted services to be structured and delivered. The act introduced a number of fundamental changes in the organisation and delivery of care with the internal market and contract culture introduced for the first time into the National Health Service. This was seen by many as a major political turning point, emphasising
individualism as a key feature (Watson, 2001). This period led to a degree of unrest with many concerned that the NHS was moving away from its core principles. The focus of service was pointed at the acute sector and as such resources were aimed at hospitals rather than primary care. This led to many rebranding ‘care in the community’ as ‘care by the community’. The introduction of the Patients’ Charter (DH, 1991) and the emphasis on the central role of primary care in the NHS (DH, 1997) began the redefinition and redirection of the National Health Service. The 1997 election of a Labour government began a new era of primary care services and development and one which we are still redesigning and evaluating today.

Policy context

Following the election of the Labour government in 1997, radical changes have occurred within primary care services. The internal market was abandoned and NHS community trusts were abolished. They were replaced with primary care groups and, subsequently, primary care trusts (PCTs), whose aims were to establish local need and provide services to meet those needs. There has also been an explosion of national service frameworks and clinical guidance fuelled by an interest in evidenced-based practice and a standardisation of care across the country. The government introduced targets into most areas of the NHS, including the 4-hour maximum wait target in accident and emergency departments, the 17-week maximum wait for outpatient appointments and the introduction of the quality outcome framework (QOF) into general practices where extra money is available for those practices meeting certain targets.

The ways in which primary care services were delivered were also radically redesigned. General medical services (GMS) and personal medical services (PMS) schemes were developed allowing general practitioners more freedom and the requirement for individual practices to provide an out-of-hours service became the PCTs’ responsibility. This resulted in the employment of many advanced nurse practitioners to staff out-of-hours services in some areas. Appropriately educated nurses were, after many years, able to prescribe some medications and this in recent years this has been extended to include all the British National Formulary, with the exception of some controlled drugs (although this is expected to change in the near future) (see Chapter 6 for further information).

In 2005 further radical changes were announced about the structure of primary care trusts, with the introduction of commissioning within the National Health Service which has fuelled fear and anxiety as well as opportunity and excitement. Primary care trusts were required to split into provider and commissioning functions. The commissioning arm of the primary care
trust is responsible for conducting health needs analysis and commissioning services to fulfil health needs. There is no guarantee that the provider arm of the same PCT would be awarded these contracts and they would need to tender against other companies interested in providing the service ensuring contestability. There are further requirements that ensure that PCT provider services are operating at arms’ length from the commissioning arm of the PCT (DH, 2005b). (See Chapter 12 for further information.)

These developments have provided nurses with many opportunities to develop their roles and services but these developments also place a responsibility on nurses to develop skills in other areas such as business management, commissioning and running a social enterprise. Advanced nurse practitioners are ideally placed to develop these skills and will find themselves using them more and more in future.

**Development of advanced nurses**

While nursing and nurse education remained quite static in the United Kingdom during the 1950s and 1960s, revolutionary developments were happening in the United States of America. Within the medical profession there had been an increase in specialisation during this time. This had led to a large number of physicians leaving primary care, creating a shortage of primary care physicians and leaving many areas, especially rural areas, understaffed. In 1965, the Medicare and Medicaid programmes provided healthcare coverage to low-income women, children, older people, and people with disabilities. The sudden availability of coverage increased the demand for expanded primary care services. Because physicians were unable to meet this demand, nurses ‘stepped into the breach’ (Medicare Payment Advisory Commission, 2002). Nursing leaders believed that nurses were qualified to expand their roles and meet the need.

Some nurses and physicians opposed the nurse practitioner model. Certain nursing leaders believed that nurse practitioners were no longer practising nursing, that the title was ‘ambiguous and misleading’ and that such training in primary care medicine would ‘control and devour nursing education and practice’ (Nichols, 1997). Despite this, nurse practitioners continued to grow in number and autonomy in response to an expanding need for accessible, cost-effective care (Division of Health Care Services and Institute of Medicine, 1983).
Emergence of the advanced nurse practitioner in the UK

It was not until the late 1980s and early 1990s that the concept of the advanced nurse practitioner travelled across the Atlantic. The first nurse practitioners worked predominately in primary care settings, such as GPs’ surgeries and homeless projects. Similarly, the majority of nurse practitioners are employed within primary care today (Ball, 2006). The Royal College of Nursing (RCN) in 1992 provided the first education preparation for advanced nurse practitioners with 15 nurses graduating; this set the precedent for many more to follow.

The RCN (2008) now defines an advanced nurse practitioner as a registered nurse who has undertaken a specific course of study of at least first degree (honours level) and who:

- makes professional, autonomous decisions for which she or he is accountable
- receives patients with undifferentiated and undiagnosed problems and makes as assessment of their healthcare needs, based on highly developed nursing knowledge and skills, including skills not usually exercised by nurses, such as physical examination skills
- screens patients for disease risk factors and early signs of illness
- makes differential diagnosis using decision-making and problem-solving skills
- develops with the patient an ongoing nursing care plan for health, with the emphasis on preventive measures
- orders necessary investigations and provides treatment and care both individually and as part of a team and through referral to other agencies
- has a supporting role in helping people to manage and live with illness
- provides counselling and health education
- has the authority to admit and discharge patients from their caseload and refer patients to other healthcare providers as appropriate
- works collaboratively with other healthcare professionals and disciplines
- provides a leadership and consultancy function as required.

In tandem with the development of the role of the advanced nurse practitioner in the United Kingdom, in 1992 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) produced The Scope of Professional Practice (UKCC, 1992). This framework allowed nursing staff, where appropriate, to extend their roles giving them more professional
freedom to take on responsibilities aligned to their practice environment. Although nurse theorists had shunned the use of the medical model within nursing advocating a holistic nursing approach to care, a British survey found that all advanced nurse practitioners were largely involved in work previously considered the domain of medicine and working within a biomedical model framework (National Health Service Management Executive (NHSME), 1996).

To support this contextual change within the field of primary care the Department of Health (DH) produced the framework *Liberating the Talents* (DH, 2002). This document proposed practical support and guidance on education and training. It emphasised 10 key roles (see *Box 1.1*) and three core role functions for nurses: first contact, chronic disease management and health protection and prevention. The DH collaborated with the National Health Service University (NHSU) to develop a work-based education programme, pushing the boundaries of nursing beyond its traditional safety net. The programme *First Contact* offered patients an acute high-level assessment within the primary care setting by advanced-level nurses.

**Box 1.1 Ten key roles for nurses**

1. To order diagnostic investigations such as pathology test and x-rays
2. To make and receive referrals direct to, say, a therapist or pain consultant
3. To admit and discharge patients for specified conditions and within agreed protocols
4. To manage patient caseloads for, say, diabetes or rheumatology
5. To run clinics for, say, ophthalmology or dermatology
6. To prescribe medicines and treatments
7. To carry out a wide range of resuscitation procedures including defibrillation
8. To perform minor surgery and outpatient procedures
9. To triage patients using the latest IT to the most appropriate health professional
10. To take the lead in the way local health services are organised and the way in which they are run

(Department of Health, 2002)

**Development of new advanced nursing roles**

Advanced nursing roles within primary care have continued to grow in recent years. Since the introduction of the community matron role (DH, 2004b) and contestability within the field of primary care (DH, 2005b, 2006) the advanced nursing concept appears to have gathered greater momentum, with
the Department of Health emphasising the need for primary care nurses to provide higher levels of assessment related to physical, mental and social needs in order that they may prevent unnecessary hospital admissions; reduce the length of stay of necessary hospital admissions; and improve patient outcomes and ability (DH, 2004b). As good practice guidance, the Modernisation Agency alongside Skills for Health have produced a further document entitled *Case Management Competencies Framework* defining both the skills and knowledge of this new breed of primary care practitioner. The document suggests this will mean working at a level commensurate with the advanced practice requirements set by the Nursing and Midwifery Council (NMC) (DH, 2005c).

There has been a plethora of interest in the development of nursing in the home, the management of long-term illness conditions and the prevention of hospital admissions; however, there has been less activity in relation to public health. Despite promises made in Choosing Health (DH, 2004a) little money has truly been invested within preventive care. However, this trend may soon change with an increased emphasis on prevention of ill health and the role of the public health nurse in recent months. The role of the public health nurse equates well with that of an advanced practitioner (Burley et al., 1997).

Indeed, Labonte (1986) asserts since health is primarily an outcome of socioeconomic structures, public health workers must become a moral voice in the struggle to end social inequality. In practice, many health visitors do indeed plead their clients’ cases with, for example, housing departments. It follows that the advanced practitioner in health visiting, in order to advance practice, may have to become explicitly political to truly embrace the new public health model and an advocacy function in practice. The advanced health visitor should not only work with groups such as minority and feminist groups and trade unions but should also be critically analytical in charting out health implications of policy and change (Luker and Orr, 1992).

**Summary**

The context in which primary care is being delivered is constantly changing and will continue to change in the future. Similarly, the advancement of nursing has happened swiftly and nursing roles will continue to evolve in the future. We face a number of demands within the United Kingdom, including an ageing population, a decreasing younger population and an ageing workforce combined with significant public health challenges, such as obesity. In conjunction, the political context is constantly changing and evolving and boundaries relating to roles and expectations are shifting. As advanced primary care nurses we must ensure that we equip ourselves with
the necessary knowledge and skills to be able to keep pace of change. Workforce planners have a hugely important job in coming years to ensure that the workforce of the future is able to respond and adapt to changes within society and to provide high-quality care to those in need as well as playing a pivotal role in the prevention of ill health. Those at the centre of this provision are advanced primary care nurses and therefore the need for such professionals is only going to grow in the future.

References

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