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Further information

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Report from the Chair: Jenny Aston

Much has happened in the last few months. Although you may not see much progress on the regulation front, there is a lot going on behind the scenes, which I am optimistic will eventually result in regulation for ANPs. Several documents published in the last few months are bringing the advanced practice agenda to the fore:

- *Supporting the development of advanced nursing practice. A tool kit approach* (Scottish Government)
- *The scope of practice, standards and competencies of the advanced practice nurse* (International Council of Nurses)
- *Extending Professional Regulation Working Group. Interim report* (Department of Health)
- *Towards a framework for post-registration nursing careers* (Department of Health)
- *Advanced nurse practitioners – an RCN guide to the advanced nurse practitioner role, competencies and programme accreditation* (RCN).

If you are not familiar with these documents do read them at www.rcn.org.uk/npa

I was able to put a question on advanced practice to Gavin Larner, DH Director of Professional Regulation, during one of the plenary sessions this year at RCN Congress. His answer: "we are going to move forward quickly on this". Although I was sceptical, the interim report on regulation was published less than six weeks later.

Risk management

ANPs are but one of many professional health care disciplines seeking regulation. A key characteristic defining advanced practice appears to be risk management so in terms of advanced nursing practice this clearly works in our favour for statutory regulation. The next DH meeting is in November when we should know more.

“... measure the contribution you make to health care so what you do is recognised, and properly remunerated and valued.”



Back row: left to right: Noeleen Fearon, Liz Davidson, Ghislaine Young, Clare Morran, Benny Harston: Front row, left to right: Linda Penny and Jenny Aston

Given all this external activity I approached other forum chairs to assess their level of interest in advanced practice and was really surprised to find that this was very high! Steve Jamieson, new RCN Head of Nursing, agreed to fund a day of discussion and workshops on advanced practice in September and although much of this work has been done before, the time seems right to work with other forums to gain broad agreement on what advanced practice is and how the RCN can support nurses working at that level.

PBC

I urge you to get involved in practice based commissioning, one of the ways we can safeguard advanced nursing roles, and become more involved in planning services

Letter from the Editor: GHISLAINE YOUNG

Sit back and enjoy this packed autumn edition of *Fast Forward*!

- Jenny Aston (working tirelessly on our behalf) has the latest on ANP regulation from the Department of Health on page one.
- Lynn Young briefs us on the Darzi Review on this page.
- Liz Davidson, Linda Penney and Noleen Fearon have updates on what is happening in their three countries on page eight.
- There's excellent advice from the Medical Protection Society (page four) on safe prescribing and how to avoid ending up in court for negligence!
- And two very different practising nurses – Benny Harston in

rheumatology and Clare Morran in acute medicine – give us their insights starting on page five.

Both articles make me feel so proud to belong to the family of ANPs because there we are, wherever we work, combining the talents and abilities of medicine and nursing in the one clinical role as well as working in teams to deliver excellence in patient care.

Talking of which, that is pretty much the title of our upcoming ANP conference on 14–15 November (see page five). As well as covering many clinical topics we will be introducing David Burrows-Sutcliffe, a renowned lawyer and an informative and entertaining speaker on medico-legal

issues. Miss it at your peril!

We often have the privilege of sharing our patients' lives when they are in crisis. Communicating with them, and actively listening, reminds us of our shared humanity and also helps us remember what really matters in life. That's why I hope my review of Anna Donald's *BMJ* blog on page five tempts you to go online and find out more about this remarkable woman.

Are you willing to let another person change you?

Those of us of a "certain age" (like me!) will remember Alan Alda, the actor who portrayed the wisecracking surgeon Hawkeye in the long-running TV series *MASH*. His autobiography, *Never have your dog stuffed*, makes good reading and his definition of listening is very powerful

Report from your RCN Adviser: LYNN YOUNG

Dazri offers much to be optimistic about

Important events have taken place in the NHS since your last newsletter, most significantly the launch of the Darzi *NHS next stage review* and the new *Primary and community care strategy*. The documents describe the way forward for the NHS in England, apparently for the next decade.

You will remember the NHS Plan – Alan Milburn's baby – which was also supposed to be a ten year delivery plan, but has now been superseded by the good works of Lord Darzi.

It's the easiest thing in the world for nurses who have been around the system for a number of years to be cynical about government white papers, strategies, plans and initiatives. However, the nursing message has clearly got through to the people who do the business in the corridors of power as the Darzi Review contains much for nurses to be optimistic about.

Nurses key to personalised services

The current theme of the Department of Health (England) is quality, quality and more quality as well as a huge component on the ability of the NHS to provide

“The nursing message has clearly got through to the people who do the business in the corridors of power ...”

genuine personalised services to patients and the public.

And this is where nursing steps in as it is the nursing discipline which holds the key to improving the environment of care, personalised care and care which promotes dignity and respect for patients.

Here is a highly abridged and edited version of the Review, which has implications for all nurses practicing at advanced level, regardless of the setting in which they work:

- a new constitution to enshrine the rights and responsibilities of staff and patients
- high quality care provided to all patients
- good health promoted in the workplace and NHS
- clinicians able to provide the most clinically-effective services

- health care organisations rewarded for good clinical outcomes and PROMS (patient reported outcome measures)
- greater choice re general practice for the public
- pilots for personal health budgets
- a personalised care plan for patients with long term conditions
- PCTs funding drugs which have been approved by NICE
- new focus on clinical leadership
- no new national targets
- more foundation trusts.

As time goes by it will be interesting to see if any of these are picked up by Scotland, Northern Ireland and Wales.

The most significant health divide between England and the other countries is, of course, the issue of increased competition within general practice. Despite huge opposition from the BMA, English PCTs continue to commission general practice services from the commercial sector.

The truth is that despite 60 years of the NHS and its commitment to equity of service provision, poor areas in the UK continue to be underserved by primary care services. While the policy is to ensure that much improved primary care is developed in areas of social deprivation, it remains to be seen if increased competition and tendering processes achieve this worthy aim.

– it really says all we need to know about effective communication:

“You have to listen so simply, so innocently, that the other person brings about a change in you ... The difference between listening and pretending to listen, I discovered, is enormous. One is fluid, the other rigid. One is alive, the other stuffed. Eventually I found a radical way of thinking about listening. Real listening is a willingness to let the other person change you. When I’m willing to let them change me, something happens between us that’s more interesting than a pair of duelling monologues. Like so much of what I learned in the theatre, this turned out to be how life is too.”

And I guess that’s how nursing works too!

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CONTINUED FROM PAGE ONE

which need our skills. I also encourage you to find ways to measure the contribution you make to health care so what you do is recognised, and properly remunerated and valued.

Restructuring within the RCN has resulted in a proposed rationale of the number of forums. We should know our fate soon and I’m hoping we will remain as a forum and change our name to the Advanced Nurse Practitioner Forum.

Benny, Ghislaine, Liz and I were pleased to be able to go to ICN ANP Conference in Toronto in September and will report back on what is happening internationally on the nurse practitioner scene.

NPA Conference time!

See page five for details of our own annual conference in November – not to be missed! You can catch up with colleagues, develop your understanding of important medico-legal issues and update your skills in various clinical specialisms such as dermatology, cardiology, neurology, mental health, paediatrics, plus lots more.

Many of us find it hard to get time off or funding which is why we have carefully chosen topics to help persuade employers and delegates that the conference is good continuing professional development. Students

Thanks to DAWN DANN and HILARY WALSGROVE, NP Programme leaders at Bournemouth University, for this review.

Wessex Nurse Practitioner Group holds inaugural conference

Our very successful conference, held in a lovely hotel overlooking Bournemouth Bay on 4 July, mainly targeted qualified and student nurse practitioners working in the local area of Dorset, Wiltshire and Hampshire, but was open to all nurses interested in advanced and advancing nursing roles.

The event attracted 80 delegates from across the south of England and from a variety of practice areas, both in primary and secondary care settings.

With enough time made available during the day for networking, old and new friends embraced this opportunity to reflect together on what they were doing, renew contacts, share best practice and explore problems.

In view of the excellent evaluations, we’ve decided this will be an annual event by WNPG. To express an interest in next year’s conference, send us your email address and we’ll keep you posted.

Email: Dawn Dann at: ddann@bournemouth.ac.uk or Hilary Walsgrove at: hwalsgro@bournemouth.ac.uk

pay 40 per cent less and groups of six or more get a 10 per cent discount. It’s worth doing some research as there are many sources of sponsorship including the RCN itself.

We guarantee you will leave conference feeling inspired, with renewed energy and having enjoyed yourself! Please make every effort to be there, and then do come and meet your committee! We’ll be delighted hear all the issues that matter to you!

Email: jennifer.aston@nhs.net



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Errors in prescribing are a national problem. Here's sound advice from an expert – JULIE WILSON, Clinical Risk Manager with the Medical Protection Society.

Positive prescribing: My top 10 tips!

Every year, 720 million prescriptions are issued in primary care so it is no surprise that errors are common.¹ A study by Barber and Dean found that in one week in the North Thames region, pharmacists intercepted over 900 prescribing errors they thought could have resulted in severe morbidity or death.²

Another study by Shah et al, carried out in the UK over a two-month period, showed a prescribing error rate of 7.46 per cent for over 37,000 items prescribed by 23 GPs.³

I am part of the MPS Risk Consulting Team which undertakes risk assessments of general practices. We analysed data between 2004 and 2006 to identify the most common risks in general practice and found that one of the highest sources of error was prescribing: 92 per cent of the practices we visited had risks associated with prescribing.

So what can we do to minimise the risks?

1. Be aware of human factors

To err is human: we all make mistakes. As James Reason, professor of psychology, said: "We can't change the human condition, but we can change the conditions humans work under." Among human factors that can cause error:

- fatigue – sleep deprivation
- hunger – long lapse between food/drink
- lack of concentration
- stress
- distraction – interruptions
- lack of training
- lack of access to information
- alcohol, drugs, illness and other factors.

2. Work within your skills and expertise

Only ever prescribe within your level of experience and competence – and in areas which also have been agreed with your employer. When you prescribe, you are responsible for the prescription and you should ensure that you have appropriate professional indemnity.

6 92 per cent of the practices we visited had risks associated with prescribing. 9

3. Monitor patients on toxic medications

When prescribing, make certain there is a safe audit system to ensure they are appropriately monitored.

4. Check patient identity before prescribing

Be sure you have the correct patient on the computer or the correct paper medical records: this requires checking and rechecking. Be particularly careful when handling patients with similar names.

5. Verify it is the right drug and correct dosage

Drugs can easily be confused, as can dosages. Many drugs have similar names and it is easy to "click" on the wrong one – for example, clomipramine and clomiphene, penicillamine and penicillin, Depo-medrone and Depo-Provera. Why not consider removing rarely-used drugs, especially ones that are easily confused, from the computer system? It is vitally important to double-check each prescription after printing.

6. Consider drug interactions and contraindications

Before prescribing, ask patients if they are taking any other medication, including over-the-counter or homeopathic medicines. Check there are no contraindications, interactions, allergies and other potential drug reactions. Use an up-to-date British National Formulary (BNF) or computer prescribing support services. Only ignore interactions highlighted by a computer if you can justify your decision. And take particular care when patients are unfamiliar to you – for

example, temporary residents or out-of-hours patients.

7. Administer drugs correctly

Always check the data sheet for side effects, contraindications and recommended injection sites. Explain the procedure to the patient, warning of risks involved, and obtain consent. Document in the patient's records the date, batch number, type of injection and information given.

8. Advise the patient

Advise patients of any common, minor and serious side effects. Consider what you would want to know as a patient yourself. Provide information about the medication. Document the advice you have given. If you start the patient on long-term steroids, make sure you issue the patient a steroid card.

9. Avoid prescribing for yourself, family and friends

You should not prescribe for anyone with whom you have a close relationship except in exceptional circumstances.

10. Keep up to date

Make sure you have the latest local or national guidelines and standards, and prescribe accordingly. Otherwise, you may have to provide evidence to justify why you did not follow them.

Adapted with permission from MPS's spring edition of *Your Practice*.

See www.medicalprotection.org/uk/your-practice/spring2008

References

- ¹ Information Centre (2006) Prescriptions dispensed in the community in England.
- ² Barber N and Dean B (1998) The incidence of medication errors and how to reduce them, *Clinical Risk*, 4, pp.103–106.
- ³ Shah SNH et al (2001) A survey of prescription errors in general practice, *Pharm J*, 267, pp.860–862.

A review by GHISLAINE YOUNG.

'From the other side': The Anna Donald blog

I came across this blog on the *BMJ* website, having been alerted to it by the former Editor, Dr Richard Smith.

Mystified, I clicked the link and entered the world of Dr Anna Donald. I found myself awed, inspired and humbled.

Anna has degrees in history, economics and medicine, and is former Clinical Editor of the *BMJ* and ex-CEO of her own public health company. She has achieved more in her 40 years than most of us would if granted several life times!

Having pioneered evidence-based medicine (what she calls "evidology"), she combines a rigorous scientific mind with a powerful sense for the sacred, which underpins all life.

Her greatest challenge

Anna is now living in the shadow of death as she has advanced metastatic breast cancer. Yet she still manages to write beautifully, teasing out the very stuff of life and, in doing so, helping the rest of us gain profound insights into the world of living one day at a time in that "uncomfortable, ambivalent space of knowing-not-knowing which is fascinating, humbling and maddening".

Her experience touches each one of us deeply because we too are human beings living with the knowledge that we are mortal, yet seldom allowing ourselves to think about this taboo subject, let alone share our innermost thoughts or fears about dying with others.

Anna says: "more life is just more and how much do you need in this horrifically banal age of eat-till-you-drop because there is nothing else to do?" The art, it seems, is making the most of what you have ("making the meaning in the now, for the now") and realising that life until old age is a privilege not a right.

The unbearable becomes tolerable

She also shares what it's like to be a patient undergoing chemotherapy and radiotherapy "lit up like a Christmas tree on the scans". She refers to the "kindness and competence" of health professionals who have the power to transform the patient experience so that the unbearable becomes tolerable.

Trained in Vipassana, a type of Buddhist meditation, Anna explores spirituality and the mind-body connection. She describes meditation as opening her up to "a kind of joyful consciousness beyond thoughts and body which, interestingly, did not seem to be body-

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For further information and a registration form please contact:

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E: nursepractitioner@rcn.org.uk

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CLARE MORRAN reckons her role is no more special than anyone else's, but if you're doing something similar she would like to link up and compare notes.

A day in the life of an ANP in Acute Medicine

I work on a medical assessment unit (MAU) with 32 beds. We admit patients 24 hours a day from GPs, A&E and clinics, and have two consultants (sometimes!), three junior doctors and myself as an ANP, and of course the rest of the nursing team.

Alongside MAU is a Clinical Decision Unit, which tends to take the "walking wounded", mainly people referred by GPs who are not acutely unwell enough to need a bed, but their GP wants them formally assessed.

Most patients come through with acute presentations such as headache, query PE, chest pain query cause, that type of thing. The unit as a whole can be very busy, frantic even, but it is an interesting and challenging place to work.

7.30am and the day begins

I get a handover from the night nursing team about all the patients so I'm up to date with what's happening prior to the morning ward rounds starting at 8am. We have two rounds going on at the same time when both consultants are present. I join one and a junior doctor joins the other.

My role in this is to note the jobs that need doing, support the patient and write up nursing notes. The round also lets me meet all the patients and check that observations and charts are up to date as well as challenge clinical decisions that are being made, if necessary.

Following the round I hand over to the team of nurses caring for this group of patients to allow them to update. I then continue to work my way through the tasks that need doing, which may include requesting investigations such as CTs, X-rays, blood tests, exercise tests, referring to specialties for another consultant opinion, discharging a patient or maybe performing some interventions

such as pleural taps or arterial blood gases.

A varied workload

I am presently writing a "scope" package to enable me to do lumbar punctures as we frequently have patients referred in with possible sub-arachnoid haemorrhage and, because we don't always have medical staff available to perform the LP, they can be put at risk by having to wait their turn.

Usually by the time I complete these tasks, results are starting to come back in so I then need to examine the reports and make decisions on any action to be taken. I discharge the patient and/or organise further inpatient tests. Obviously our flow of patients is dynamic so new ones are arriving all day and these need to be clerked, tests ordered, results checked and decisions made. It becomes a cyclical process.

Busy, yes, but never boring!

I usually manage a break about three or four o'clock in the afternoon – there's a lull before scan results are back so it's a good time to catch up on emails for 20 minutes before returning to the madness!

Usually a pile of CTs and VQ scans results come back about 5pm so although I am supposed to go off duty at 5.30, this is rare. I work four x 10-hour day shifts at present.

I am currently the only ANP in acute medicine. I'm told the role is a success and the department couldn't manage without me so why haven't they funded more posts such as mine? Maybe I haven't managed to demonstrate its value so if anyone else has, please let me know how!

Obviously a lot of my work also involves supporting the nursing team as well the junior medical staff and medical students who are frequently on the ward looking terrified!

Respect for primary care colleagues

All patients are seen by a consultant before being allowed to move onto a base ward or discharged so I guess really my work is far less autonomous than a lot of you who work in primary care.

I have huge amounts of respect for all of you out there. I have the luxury of bloods, ECGs, CT scans and so on as well a medical team to hand if I need them – plus radiologists or other specialists to consult with. My biggest challenge at times is getting so many different teams (and egos!) to work together for the sake of the patients as well keeping the flow of patients moving through the unit.

I hope this provides you with a reasonable idea of my day and if you are in a similar environment, do email me. I absolutely love the role, but it can be quite a lonely existence!

Email: clare.morran@nhs.net

CONTINUED FROM PAGE FIVE

beholden", adding wryly this is somewhat comforting when, facing imminent death, "the lease on your body runs out"!

Where science meets the sacred

Anna uses her amazing scientific brain to explore metaphysics or the world beyond the material. To her, "all things are sacred if you choose to allow yourself to be plugged in". She also reflects upon the nature of science "that wonderful, slow tortoise" which evolves gradually by making sense of what has gone before and only occasionally making revolutionary leaps in understanding.

Her words made me realise that so much in life that is a "fundamental truth" is in fact a paradox, such as life and death, the material world and the spiritual. I too have always been fascinated by the meeting of science with the sacred and Anna makes the two appear not as polarities, but as complementary – maybe two sides of the same coin?

I urge you to enter Anna's world for yourself at: <http://blogs.bmj.com/bmj/category/from-the-other-side>. You will be enriched and transformed by the experience and maybe learn to look up at the stars now and then, and count your blessings.

BENNY HARSTON hopes that by disseminating details of this small but successful initiative she will inspire other nurses working in primary care to focus on quality and equity of services.

A nurse-led clinic enables holistic care for patients with rheumatoid arthritis

I am a nurse practitioner attached to a rural practice in the heart of the Norfolk Broads. Our 8,500 patients include a high percentage of older retired people, many with long term conditions.

In 1994 my occupational therapy colleague (Karen Rushmer) and I set up a small clinic dedicated to our patients with arthritis, aiming to bring them holistic, timely care alongside their care for other co-morbidities.

I was then working towards completing my BSc (Hons) Nurse Practitioner course and, as part of this plan, I opted to do an extra module encompassing the care of patients with inflammatory arthritis. This was successfully completed.

In primary care about 25 per cent of presentations relate to muscular-skeletal problems so the more we focus on this area, the better for patient care. Considerable progress has been made in managing rheumatoid arthritis (RA) over recent years.

Support for both new and existing cases

The emphasis is now on early diagnosis. In a practice our size we expect to see eight new presentations of RA each year and one aim is to see that these patients are assessed early and referred in an appropriate and timely manner.

We also recognise another key goal to support patients with existing inflammatory conditions and make sure they have physical and emotional support, and access to appropriate services.

We have many patients on disease modifying anti inflammatory rheumatology drugs (DMARDs) who need to be monitored at regular intervals.

This offers a good opportunity for nurses in primary care to identify them and assess their risk factors for ischemic heart disease (an independent risk factor for patients with RA), monitor for infections and ensure vaccinations are up to date, especially pneumonia and influenza.

We also deal with flares and pain management, and look out for uncommon but serious extra articular manifestations of RA such as vasculitis and the development of malignancy, all in a timely manner.

By promoting clinic-based care of these patients we feel these factors will be dealt with in a less *ad hoc* manner.

Easing pressure on hospital services

Patients like being able to get comprehensive care in practice and we have developed excellent working relationships with the local rheumatology service at the Norfolk and Norwich University Hospital. We are now reducing hospital appointments by taking on the follow-up care of many patients, thereby freeing up consultant/hospital appointments and improving the patient journey.

We have also held several patient information evenings where we were fortunate in having various consultants from the local hospital come to talk about different aspects of RA – 35 patients attended the last one and the networking was one of the main strengths of the evening.

If you would like to know more about how to set up a clinic and see our clinic guidelines, email me at benny.harston@nhs.net

UPDATE

NHS Clinical Knowledge Summaries

NHS Clinical Knowledge Summaries (CKS – formerly PRODIGY) are a freely available, reliable online source of evidence-based information and practical know how about the common conditions managed in primary and first-contact care.

Currently 12,000 people a day use the CKS website (www.cks.library.nhs.uk) to make decisions about the management of their patients, for learning and continual professional development, and for the development of protocols, patient group directions and care pathways.

To enhance the service the first in a series of CKS audio **podcasts** have been produced on “hot” clinical issues such as:

- diagnosis, management and follow-up of acute anaphylaxis
- reducing antibiotic prescribing for otitis media with the use of deferred prescriptions
- referral for breast cancer and promoting breast awareness
- missed contraceptive pills
- managing red eye
- evidence for the use of varenicline in people who want to stop smoking.

They're at: www.cks.library.nhs.uk/knowledgeplus/podcasts

In response to feedback, new **training materials** on using or teaching others about the CKS are at:

www.cks.library.nhs.uk/about. These consist of:

- a user guide for the website available as a video, PowerPoint and PDF document
- an overview of CKS (PowerPoint or podcast)
- training scenarios.

Feedback about the podcasts and training materials would be greatly appreciated by rachael.parslow@schin.co.uk

CKS will be exhibiting and providing demonstrations at the RCN NPA Conference at Liverpool on 14–15 November.

NPS AROUND THE UK

NORTHERN IRELAND: Noeleen Fearon

Giving everyone a chance to gather themselves after Christmas and New Year,

NPs in Northern Ireland commenced their forum meetings in February with an update on smoking cessation, including a presentation on the drug varenicline, which we're not yet authorised to prescribe owing to its "black triangle" status.

Disappointingly, the March meeting was cancelled through lack of interest – perhaps too close to Easter?

In April we had an excellent talk on the menopause and hormone replacement therapy by the specialist nurse from a local menopause clinic. A sit-down meal afterwards gave us a chance to network and relax together. And later in the month there was a whole study day on travel health, which was well attended and informative.

May saw two meetings: an update on the management of psoriasis including topical treatments, concordance and the effect of this disease on patients'

quality of life; an interactive event on asthma when NPs brought along clinical questions and case studies for a highly enjoyable session.

We hope to meet soon with Basil McCrea MLA (Member of the Legislative Assembly) as he has shown an interest in health issues and can perhaps help us raise the profile of Nurse Practitioners in the province.

We still have not managed to sort our X-ray issues, but are hoping to start the necessary course in ionising radiation in the near future.

SCOTLAND: Liz Davidson

It has been a busy year in Scotland with activity around Modernising Nursing Careers exploring how to achieve a consensus on advanced practice.

I attended the Advanced Practice Consensus Conference in Jun where the Advanced Practice Toolkit was launched. This toolkit will be available to managers and service providers from November of this year, giving employers a feel for the level of education and training required to work at an advanced level.

It's always important to keep ANPs on the radar so to this end a fellow ANP, Fiona McLeod, and I presented two workshops on ANPs in general

practice at the Royal College of GPs/ GMS Contract conference in Aberdeen in February.

Feedback from both workshops was positive and there was interest in developing this type of role, but one of the stumbling blocks they stated was difficulty in getting funding for the correct education and training, with the salary implications of the ANP post. We had an easier time in the first group as my practice manager was there and she couldn't support the role enough!

The Grampian and North Advanced Health Care Practitioner Network continues to meet with teleconference

links with Moray and Orkney. It really is good to share ideas with fellow advanced practitioners and anyone interested in joining can email me for more information.

Finally – I was invited to attend a champagne celebration for the graduation of the first cohort of NP students from the Robert Gordon University and to present a small gift in recognition of their achievement. It was an honour to do so and I've no doubt that these new nurse practitioners will continue to develop and promote the role in the north east and beyond!

Email: liz.davidson@peterculter.grampian.scot.nhs.uk

WALES: Linda Penny

Some 35 NPs from primary care, secondary care and education settings in Wales have expressed an interest in e-networking. We are not active yet, but we have had early discussions regarding meetings and we are very enthusiastic! Most interest is from South Wales so I would love to hear from NPs in Mid and North Wales.

NHS Wales in a state of flux. Edwina Hart, Minister for Health at the Welsh Assembly Government, is reviewing local health boards with the likelihood of the current 22 boards becoming five in alignment with trust hospital areas. We should know more very soon as the changes are due to happen in April. It is therefore more important than ever that nurse

practitioners are in touch with each other to offer support and guidance.

I have established links with the RCN Practice Nurse Forum and was invited to attend their conference in Cardiff in July. It was a great opportunity to explain our role and discuss how we can work together.

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