



Commissioning a patient led NHS

A TOOLKIT FOR NURSES



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Introduction

Over the last year, many changes have taken place in the health service, not least the way in which services are commissioned and provided. The Department of Health (DOH) is keen to create an NHS where there is more choice, more individualised care and real empowerment of patients to improve their health.

The document *Creating a Patient Led NHS* (2005) outlines what changes will be made to facilitate this, including ensuring that independent sector providers are able to be on the list of options for a patient, encouraging the development of new services and developing local services and patient pathways. The document *Commissioning a patient led NHS* (2005) identified key changes to the way services are commissioned and the changes needed to PCTs and SHAs to achieve this. In November 2006 the DoH issued further guidance in the paper *Practice based commissioning: practical implementation*.

It is important that nurses are aware of these changes, how they may be affected by them and how they can optimise the opportunities they provide. The paper *Modernising nursing careers setting the direction* (2006) clearly identifies the need for nurses to respond to new challenges, to be prepared to work in different ways and for different organisations, and most importantly sees nurses as **leading, co-ordinating and commissioning** care as well as giving care. This toolkit will provide an explanation of commissioning, the different ways services can be commissioned and its relevance to public health and long term conditions, as well as practical steps for nurses wanting to become involved in any stage of the process.

The advice in the toolkit will be of use to nurses, midwives, health visitors and allied health professionals. For the ease of writing, we have referred to nurses throughout.

What is commissioning?

“The purpose of commissioning is to maximise the health of a population and minimise illness by purchasing health services and by influencing other organisations to create conditions which enhance people’s health.”

(Ouvriet, J. Purchasing for Health Oxford University Press 1995, p.18)

Commissioning is the process whereby organisations identify the health needs of their population and make prioritised decisions to secure care to meet those needs with the available resources. Practice Based Commissioning (PBC) transfers these responsibilities, along with associated budgets, to GP practices.

Commissioning, purchasing and contracting are not one and the same activity, despite the terms often being used interchangeably. Purchasing is a narrower activity concerned with buying the best value for money services to achieve the maximum health gain. Contracting is simply the selection of a provider and the negotiation of an agreement to provide an appropriate quantity and quality of service. Purchasers are those organisations that hold a budget and purchase services from providers, this may be their own organisation, other NHS departments or those in the voluntary or independent sectors.

Practice Based Commissioning

Under Practice Based Commissioning (PBC), GP practices will take on responsibility from their PCTs for commissioning services that meet the health needs of their local population.

Commissioning practices, or groups of practices, will have the following main functions:

- designing improved patient pathways;
- working in partnership with PCTs to create community based services that are more convenient for patients;
- responsibility for a budget delegated from the PCT, which covers acute, community and emergency care;
- managing the budget effectively.

Under PBC GPs will not be responsible for placing or managing contracts. That will be done by PCTs on behalf of practice groups. GP Practices will also receive management support, the size of which will be dependent of the numbers of practices involved.

This means that PBC will provide opportunities for new ways of working and for new service providers to be considered to deliver care to groups of patients or clients.



Why do nurses need to know more about commissioning?

The changes to commissioning are happening and nurses, wherever they work, need to engage in this process. The Government has identified the desire for better clinical engagement in the commissioning process as one of the drivers for *Commissioning a Patient-led NHS* (2005); and the White Paper *Our Health, Our Care, Our Say: A new direction for community services* (2006) argues that PBC is key to achieving improvements as it:

'...will act as a driver for more responsive and innovative models of joined up support within communities, delivering better health outcomes and well-being including a focus on prevention.'

Rosemary Cook, Director, Queens Nursing Institute, speaking at the London Network Primary Care Group Event in November 2005, argued that changes to commissioning will result in 3 crucial trends which will open up a range of opportunities for nurses, midwives and health visitors. These are:

- Localism
- Pluralism
- Entrepreneurialism

An exploration of these will help to identify why nurses need to get involved in commissioning and some of the knowledge and skills they need to develop to do this effectively.

Localism

The principle of localism is a health care system where decisions are made locally and where the front line professional's knowledge is valued. This results in empowered clients and communities. Commissioning at a more local level will allow nurses to:

- To have a greater influence on services
- Directly improve care outcomes
- Help shape policy
- Combine clinical work with other roles
- Make local knowledge count
- Learn new skills
- Work for a different organisation

Pluralism

New ways of commissioning will allow for different ways of doing things and for nurses to meet their full potential. This will provide nurses opportunities to:

- Change traditional ways of working
- Make time and space for improvement
- Bring new kinds of people into health care
- Bring new money into primary care
- Develop professionally
- Try out different roles

Entrepreneurialism

This is probably the most radical opportunity for nurses and midwives brought by changes in commissioning. Being entrepreneurial is a mindset in which business skills are employed allowing for ingenuity and creativity in planning services for clients. It will allow nurses to:

- Reshape services for patients
- Expand individual roles
- Combine clinical work with service planning and development
- Combine provision role with commissioning role
- Move into partnership with other staff
- Start their own health care practice or business.

The degree of involvement by individual nurses will obviously depend on their current role and desire to participate in the process. Whatever your individual decision is, it is important that nurses at all levels do engage with commissioning and not miss the opportunity to influence the direction of service provision for patients and clients.

In summary, nurses can be involved at various stages by:

- Finding out what is happening in their local area, so that they can make sure that they, patients and colleagues are aware of new services
- Get involved in commissioning groups, either as members or attending forums, to keep informed and to contribute to the planning and feedback of services
- Learn new skills such as those needed for caring for patients with long term conditions, community profiling and health needs assessment, and business skills to enable them to set up new services.
- For the more enterprising nurses there are now exciting business opportunities including nurse partnerships ([see page 9](#))

The Commissioning Cycle

The commissioning cycle describes the main stages of the commissioning process, and tasks to be addressed within each stage.



In detail, the commissioning cycle consists of the following:

A Strategic framework

- Establish required future developments
- Establish shared values and broad strategic objectives
- Clarify roles and responsibilities
- Establish a broad approach to implementing strategy, including the phasing of planning cycles.

B Strategic planning

The key activities within this stage are as follows:

- Complete strategic needs assessment
- Identify existing services and resources
- Define priorities and agree outcomes
- Consult users, carers and providers
- Agree commissioning intentions

C Operational planning

- Establish contracting mechanisms
- Develop quality assurance requirements
- Undertake market management and provider development activities
- Establish infrastructure needs (systems and skills)

D Purchasing activities

- Agree service specification
- Select providers
- Agree contract and monitoring arrangements

E Monitoring and review

- Collect performance information
- Review provider performance against objectives or standards
- Review/re-negotiate contracts
- Feed information back into Strategic Review

Commissioning Strategy

A strategy for commissioning will need to have a systematic approach. The strategy will include ways to reduce reliance on secondary care services and increase the provision of care in primary, community and the home environments.

This can be achieved by a whole systems approach. This means that the commissioning strategy must cover the full range of services. Key areas are the boundaries between primary and secondary care services and also between health and social care. The focus should be on commissioning services not the contractual mechanism.

A commissioning strategy needs to have flexibility around the following:

- **Structures**
 - Commissioning structures are not prescribed, they must be fit for purpose
 - Have an open market for providers of primary care
- **Processes**
 - Commissioning – do what works!
 - Procurement – open competition to deliver best value
 - Contracting – range of options

Barriers to nursing involvement in commissioning

- Little engagement from nurses
- Lack of understanding by others of potential nursing contribution to process
- Lack of development of integrated commissioning
- Understanding the role of PCT's in commissioning
- Inter-professional conflicts
- Lack of understanding of who commissions primary care
- Lack of procurement expertise
- Lack of contracting expertise
- Knowledge of the health market
- Lack of business acumen

Key elements of commissioning

The following points need to be considered in the commissioning process, many of these are discussed in more depth later on in the toolkit:

- **Commissioning culture and expertise**
The role commissioning already has in your organisation, the clarity with which commissioning processes are defined, and the skills held individually and organisationally will impact on the way commissioning evolves in your area.
- **Health needs assessment (HNA)**
HNA is the first step of the commissioning process and is the most effective method to determine the health needs of communities. (See *Public Health Section on [page 11](#)*)
- **Strategic planning**
This defines how the future of health and social services will be configured, how they may differ from current arrangements and suggests clearly defined milestones toward key priorities. Provider service objectives should reflect those of the Local Delivery Plan developed within each PCT. Integrating quality within a financially constrained environment is crucial. Clinicians should use their clinical evidence base with public health data analysis to underpin the strategic plan. Defined health outcomes need to be clear e.g. the impact of the healthcare intervention, or the benefit to the user and the organisation.
- **Service Level Agreement (SLA)**
An SLA is used to formalise the recording of the arrangements between purchasers and providers of services. It includes details of the parties involved, the length of time of the agreement, monitoring, pricing and performance management arrangements. With the exception of Foundation Trusts, these are not legally binding, but are a record of the terms and conditions being worked to by the provider. Appendices are used to create bespoke agreements for specific areas.
- **User involvement**
The commissioning process must include user involvement and this goes beyond tokenistic consultation and should mean effective engagement between commissioners, service providers and users that will impact on the outcomes as well as shaping priorities and strategic planning. (See *User Involvement Section [page 20](#)*)

- **Communication**

This refers to the importance of exchange of information and dialogue between stakeholders, and the use of and relationship with the media and other forms of information sharing with the public. Articulating and presenting examples of service re design and patient story lines will add emphasis. (See *User Involvement Section page 20*)

- **Service redesign**

A key driver of 'Commissioning a patient led NHS' is the Government's strategy to develop healthcare outside hospitals, and relocate certain services in the community and primary care settings. The increase in acute care costs i.e. hospital costs combined with the increased patient demand and long waiting lists have influenced this change. Resources must be used creatively to add value and develop services in the right place, at the right time, provided by the right people. A resource management tool is provided in [Appendix 1](#).

- **Collaborative working**

Commissioning should reflect the range of stakeholder interests and recognise that much more will be achieved through partnership approaches, including strategic and financial alliances. Good examples of this can be found in Supporting People with Long Term Conditions – an NHS and Social Care Model to support local innovation and integration (2005), and Every Child Matters; Change for Children (DfES 2004). Formal and informal ways of working strengthen effective relationships between commissioners, providers, users, voluntary sector organisations and communities. Building local networks involves identifying the local champions that will make most impact in improving services. (See *Long Term Conditions Section on page 14*)

- **Education and training**

Education and training needs to be provided to support all professionals, including nurses, to enhance their understanding and expertise of commissioning at local and strategic level. (See *Education and Training Section on page 22*)

- **Business planning**

Business Planning is an important part of strategic planning and financial management. Nurses will need to develop or access business planning skills if they are to become entrepreneurs. (See *Writing a Business Plan Section on page 18*)

- **Evaluation**

Any initiative or service will need to be evaluated to measure it's impact and whether it is fit for purpose. (See *Evaluating Health Care Section on page 16*)

Commissioning and Developing Nursing Provider Models

Nurses are in an excellent position to redesign services around their patients needs. Commissioning is an essential tool for ensuring strong clinical leadership within nursing. Strong leadership will be required for the redesign of services and the development of new alternative nurse or multi-professional or organisational led provider models.

The White Paper (2005), *Our health, our care, our say: a new direction for community services*, reinforces this view by the identifying of key points for the future of nursing:

- more services to be provided in a community settings
- longer opening hours within general practice & pharmacies
- more convenient services for patients with new models of care
- extending the number of nurse-led provider services
- more integration between health and social services
- greater support for patients with long term conditions.

The table on the following page identifies possible models for commissioning and then some examples are given of how these services might look.



Contracting Route	Qualifying Providers
PCT Medical Services (PCTMS)	PCT's
General Medical Services (GMS) Pension Enhanced Service	<ul style="list-style-type: none"> • A General practitioner • Two or more individuals practising in partnership; <ul style="list-style-type: none"> - At least one partner must be a general medical practitioner - Other partners must be individuals from within the 'NHS family' • Company limited shares <ul style="list-style-type: none"> - At least on share must be legally and beneficially owned by a general medical practitioner - Other shares must be legally and beneficially owned by individuals from within the NHS family <p>NHS pension Scheme applies</p> <p>Regulations require the provision of essential services</p>
Personal Medical Services (PMS) Pension Enhanced Service	<ul style="list-style-type: none"> • An NHS Trust (including PCT's and foundation trusts) • A medical practitioner • A health care Professional • An individual who is GMS or PMS provider • An NHS employee or a GMS or PMS provider • A qualified body (a company limited by shares, all of which are legally and beneficially owned by persons identified above) <p>(or any combination of the above)</p> <p>NHS Pension scheme applies</p> <p>Regulations do not require provision of essential services</p>
Alternative Providers Medical Services (APMS) Pension Enhanced Service	<p>Any person eg Commercial providers, UK or abroad Voluntary sector Not-for-profit organisations Other PCT's</p> <p>*Not applicable for NHS Pensions Scheme this also includes staff that have transferred from the NHS</p> <p>Regulations require contracts without essential services</p>
Enhanced Service	<p>Allows for contracts with organisations solely for the provision of enhanced services i.e.</p> <ul style="list-style-type: none"> • Disease-specific • Secondary-care type services • Community services
Specialist Personal Medical Services (SPMS) Pensions	<p>Very rare but similar to PMS, provides specialist service for limited range of services e.g. women's health</p> <p>Any person e.g. Commercial providers, UK or abroad Voluntary sector Not-for-profit organisations Other PCT's</p> <p>* Not applicable for NHS Pensions Scheme this also includes staff that have transferred from the NHS</p> <p>Regulations require contracts without essential services</p>

Potential Nursing Involvement in Provider Models for the Future

Model 1: Nurse-run practice

In a nurse-run practice, the nurse acts as an independent contractor employing other staff (including a GP) to support them in providing a comprehensive primary care service to a registered population.

Organisational form – could be a professional or limited liability partnership or a limited company.

Contracting mechanism – a PMS contract is used thereby requiring no GP signature on the contract. The organisational form would determine whether PMS or APMS is used.

Model 2: Nurse-led primary care services

Nurse-led primary care services for specific population groups such as asylum seekers, travellers, or homeless people. These groups are often poorly served by general practice and often not registered with a practice. In this model, the nurse collaborates with other health and social care professionals including a GP to provide a comprehensive range of services.

Organisational form – the nurse (and other support staff) could be self-employed and have a contract with a local primary care provider or directly with the commissioning body. Alternatively, the nurse may be an employee of a local primary care provider.

Contracting mechanism – the organisational form would determine whether or not a PMS, APMS or PCTMS contract is used.

Model 3: Multi-disciplinary professional partnerships

Nurses as “partners” in multi-disciplinary partnerships (as opposed to GP partnerships) would start to offer real choices to patients, both in terms of increasing capacity and offering an alternative model of practice. Nurse partners are not necessarily new but changes in funding through the new primary care contracts has made it easier for GPs to take on nurses and others as partners.

Organisational form – a professional partnership. A nurse could become a salaried partner, a fixed share or full equal partner. A salaried partner continues to be employed as a staff member, so taking on none of the risks of a full partnership but receives an agreed part share of the practice profits in addition to regular

remuneration. A fixed share partner is self-employed and receives an agreed, fixed share of practice profits. A full equal partner is self-employed and part owner of the business with the other partners. Full partners have unlimited liabilities of the business.

Contracting mechanism – a professional partnership could use a PMS or GMS contract. They may also sub-contract for services through a SPMS contract. For example, they may contract with a self-employed nurse to provide sexual health services to people not registered at the practice as well as their own registrants

For further information see www.qni.org.uk/Nursepartners.htm

Model 4: Limited Companies

An increasing number of GP partnerships providing an enhanced range of services have set up a limited company to oversee this element of service. A suitably qualified nurse could become an Executive Director of such a company. This would offer nurses a position to influence the strategic direction of the business.

Organisational form – a limited company could provide a full or partial

Range of services to a registered or/and unregistered population.

Contracting mechanisms – the type of limited company would determine whether or not a GMS, PMS or APMS contract is used.

Model 5: Multi-Speciality Teams

Patients with long-term conditions could benefit from community based specialist teams that bring together hospital out-reach nurses, community matrons, community nurses, AHPs and physicians. The team for a particular client group or locality could hold a commissioning budget. These teams could also be commissioned to discharge patients early and transfer their care to the community. This model would potentially expand the range of services offered by nurses and others working in the community and improve access to care and patient choice.

Organisational form – this could be a limited company, a mutual or a limited liability partnership.

Contracting mechanism – this will depend on the nature of the service being provided and the legal organisational form adopted.

Model 6: Co-located nursing services

In future, nurses could be located in community facilities close to home or work such as pharmacists, children's centres or schools. This would increase patient access and offer choice of provider. It could also potentially forge different ways of working and different relationships between professionals and local communities.

Organisational form a nurse could be self-employed or an employee of another primary care provider or possibly an employee of the community facility.

Contracting mechanism – this is most likely to be SPMS.

Model 7: Primary Care Nursing Teams

Such teams could either work independently in free standing or self managed units, or are employed by a primary care. Integrated and specialist nursing teams could provide services to a range of people such as the house-bound, residential and nursing homes, schools and other community facilities.

Organisational form – a self-managed team could coexist in a range of different organisational forms. The organisational form of an independent nursing team would be determined by who is being served and the capital needs of the service.

Contracting mechanism – the organisational form adopted and the type of service being provided would determine this.

Model 8: Limited Liability Partnership (LLP)

A LLP is a written agreement similar to a partnership agreement used in traditional professional partnerships. The difference is that this is registered at Companies House. Since, organisations can also be members of an LLP, a patient organisation or an independent nursing team could be included as a member of the LLP.

Organisational form – a limited liability partnership

Contracting mechanism – this would be determined by the level and range of services being provided.

Model 9: Nursing Co-operative

A coalition of nursing groups or practices formed around a geographical area, a client or disease group could come together to form a co-operative. The

key purpose would be to co-ordinate and integrate primary care nursing services across an area. A Nurse Co-ordinator would be appointed to manage the services with financial and administrative support. Contracts could be placed with the co-operative from local commissioning bodies, other local providers and the LA.

Organisational form – a co-operative.

Contracting mechanism – this would be determined by the level of service to be provided.

Model 10: A Nursing Chambers

In this model self-employed nurse consultants or nurse practitioners join a 'chamber'. Depending on the size of the 'chamber' they may also be provided with 'junior' staff support. Self-employed nurses based in such a model could provide a range of services in collaboration with hospital consultants (and others) working across organisational boundaries or solely in a community setting. There is potential with this model for nurses (and others) to have an important role in working across organisational and professional boundaries. The service would need to be accredited not the institution. Patients would potentially benefit by receiving more specialist care in a community setting.

Organisational form – self-employed but using chamber facilities and in some cases working with others from the chamber (internal referrals).

Contracting mechanism – Nurses could work exclusively for one provider or they could have contracts with a range of different providers. In this scenario it is most likely a SPMS contract would be used.

Key Issues

Partnerships – need for robust partnership agreement and trust.

Companies – need to consider ownership of shares and what proportion

Fundamental Question – what happens if I want out?
Always get independent legal and financial advice.

For more information see article by Nicola Walsh Developing Nursing to transform Primary Care. (Paper for Department of Health Strategy Unit, May 2005) in [Appendix 2](#)

Public Health and the relationship with commissioning

Choosing Health (DoH 2005) places emphasis on prevention and early interventions which can be cost effective in reducing longer term ill health. Commissioners and providers need to stay abreast of national initiatives to improve the quality of health and social care where these may impact on health services. These will include the national service frameworks where commissioners will need to ensure that their activities contribute to improving population health wherever possible.

Commissioners will also need clinical expertise to underpin and inform the decision making process. For example practitioners will be able to advise about population needs and offer advice on how services can be delivered. Tools for identifying health needs may have been developed locally and the public health department can advise on the types available and their suitability.

The public health team within the PCT will also be able to provide professional advice and support to providers when searching for health needs, analysis of data for trends and demographics. The annual public health report will also contain relevant and useful information and statistics, which should inform service planning and delivery.

Health Needs Assessment

In 2004 the Health Development Agency produced the document 'Health Needs Assessment' as a tool for supporting service planning and evaluation. NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

What is health needs assessment?

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

Local data, health or case load profiling with activity data can

be used, with particular emphasis on health outcomes and key achievements. If data is missing now is the time to be discussing how this can be gathered. Health needs assessment should ideally be undertaken within a team to facilitate the best outcomes for the work plan. Your public health team can advise and offer local support.

Why undertake HNA?

- HNA is a recommended public health tool to provide evidence about a population on which to plan services and address health inequalities
- HNA provides an opportunity to engage with specific populations and enable them to contribute to targeted service planning and resource allocation
- HNA provides an opportunity for cross-sector partnership working and developing creative and effective interventions

What are the benefits of HNA?

- Strengthened community involvement in decision making
- Improved team and partnership working
- Professional development of skills and experience
- Improved communication with other agencies and the public
- Better use of resources.



What are the challenges of HNA?

- Working across professional boundaries that prevent power-or information-sharing
- Developing a shared language between sectors
- Obtaining commitment from 'the top' of the organisation
- Accessing relevant data
- Accessing the target population
- Maintaining team impetus and commitment
- Translating findings into effective action.

Key partners

Provider services should be developing and strengthening partnerships with alternative and complementary providers. Other organisations will often collect data that may be of use. These could include:

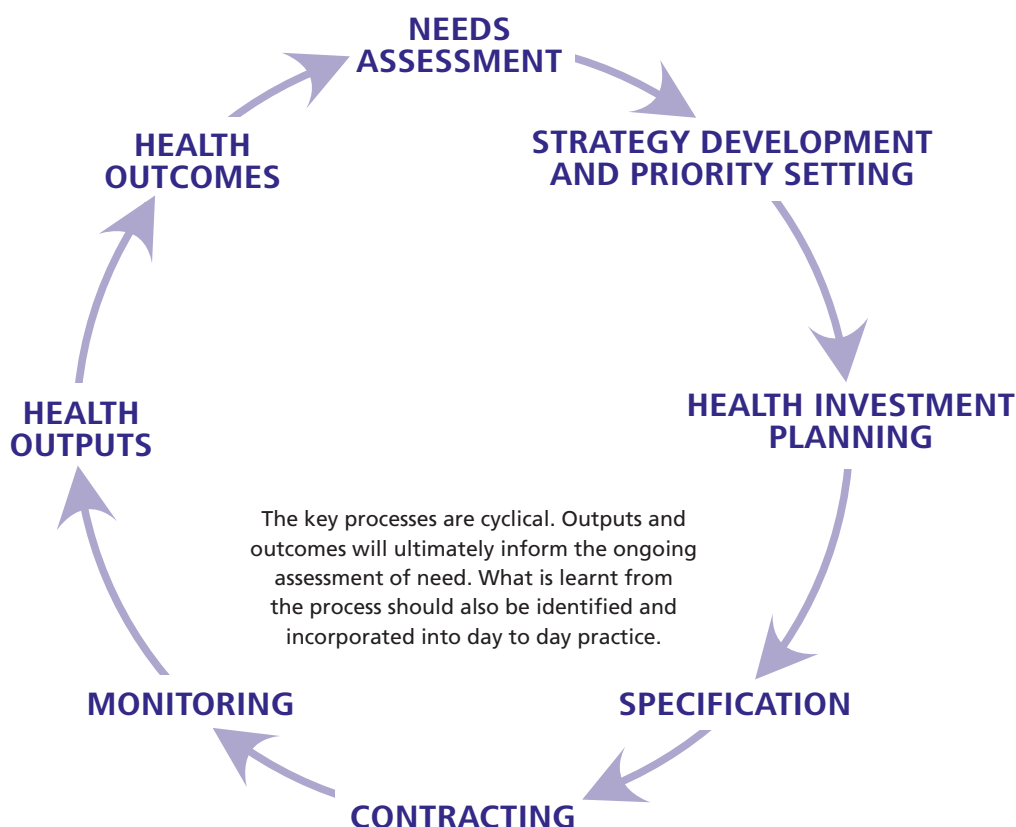
- Colleagues in social care
- Voluntary agencies
- Allied health care professionals
- General practice staff
- Private providers
- Residents and community groups
- Service users
- Parents and carers
- Local authority including education, environmental health, community partnerships and public health
- Hospital colleagues

PCTs will approach the challenges according to their locally identified needs assessments and epidemiology, and will address them in different ways.



HNA – summary of process

The Linked Process



Step 1 Getting started

- What population?
- What are you trying to achieve?
- Who needs to be involved?
- What resources are required?
- What are the risks?

Step 2 Identifying health priorities

- Population profiling
- Gathering data
- Perceptions of needs
- Identifying and assessing health conditions and determinant factors

Step 3 Assessing a health priority for action

- Choosing health conditions and determinant factors with the most significant
- Size and severity impact
- Determining effective and acceptable interventions and actions

Step 4 Planning for change

- Clarifying aims of intervention
- Action planning
- Monitoring and evaluation strategy
- Risk-management strategy

Step 5 Moving on/review

- Learning from the project
- Measuring impact
- Choosing the next priority

Further information is available from www.publichealth.nice.org.uk/download.aspx?o=513203

Long Term Conditions

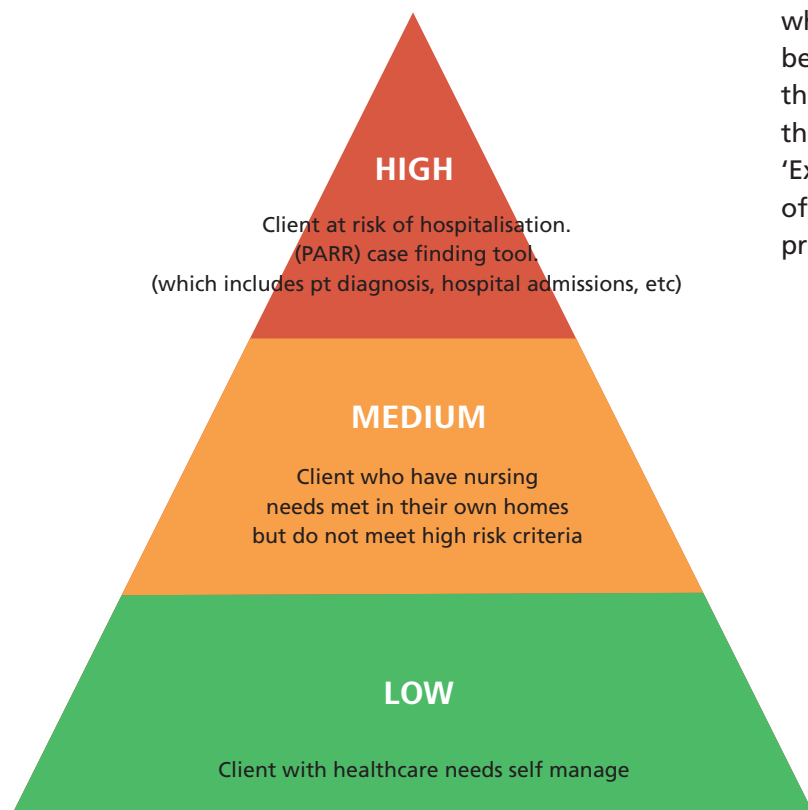
Background

It is estimated that 17.5 million of adults in Great Britain may be living with a chronic condition. It is likely that up to three quarters of people over 75 years are suffering from a chronic illness, of whom nearly half have more than one condition (DOH 2005).

Community nurses are already caring for patients with chronic illness and are making an important contribution in helping them stay as well as possible. However, generic community nurses have limitations within their competencies to provide the holistic care to support patients who have complex and multiple needs.

The government is keen to reduce the number of hospital admissions for patients with long term conditions. Evidence has shown that intensive, on-going and personalised case management can improve the quality of life and outcomes for these patients, dramatically reducing emergency admissions and enabling patients who are admitted to return home more quickly (DoH 2005). This is an ideal area where nurses can be involved in commissioning.

Triangle of need

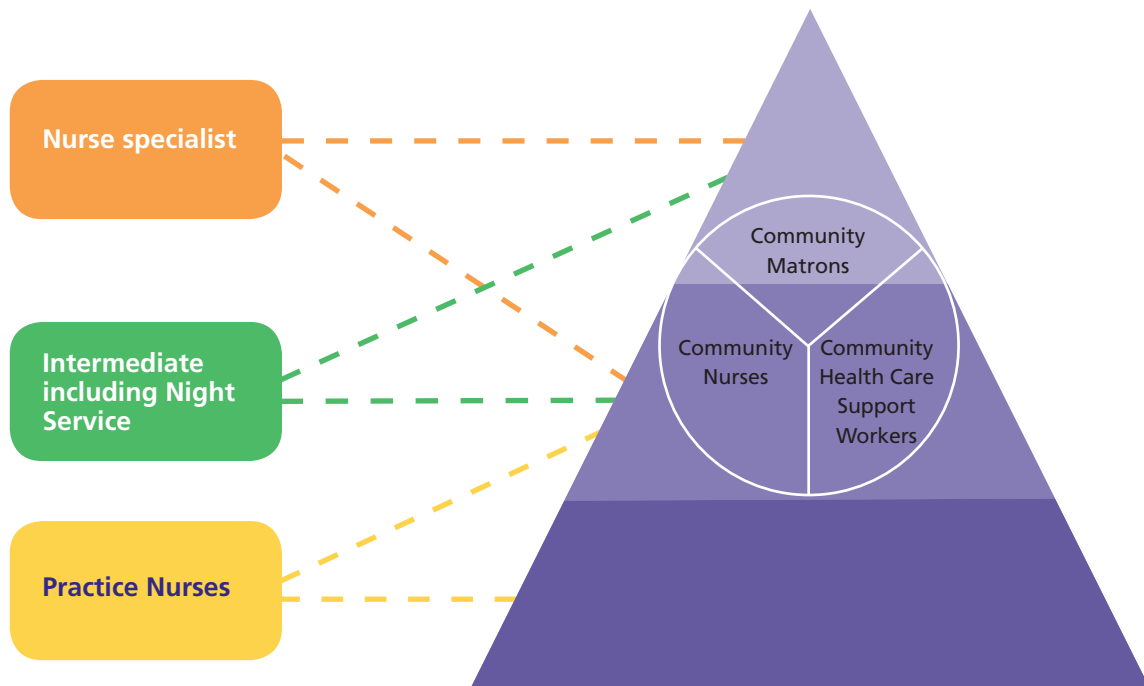


Patient needs

This triangle, based on the Department of Health model for long term conditions, shows bands of need from high to low which patients will fall into at any stage of ill health.

- A patient with **high need** is likely to have complex, often multiple conditions and will require a case management approach. The PARR (Patients at Risk of Re-hospitalisation) care finding algorithm, developed by the Kings Fund and New York University, is one tool already used to help identify these patients. The algorithm produces a "risk score" for the probability of future admissions, drawing upon a broad range of information about the patient from the current hospitalisation and any hospitalisation in the prior three years, the geographical area where the patient resides, and the hospital of the current admission.
- The **medium need** patients will have a range of nursing needs which will be best met in the patient's home. Some of these patients will also have complex needs and may benefit from case management but do not fit the criteria for high need.
- The **low risk** group will include patients newly diagnosed with a long term condition and others who can generally self care, but who would benefit from a period of health care input to help them learn about their condition and support them with appropriate health promotion advice. 'Expert patient programmes' could be a way of delivering support to this group and health promotion and prevention will form the core work.

Nursing Roles



This diagram shows who in a nursing team and extended team could be the best people to deliver the care across the 3 bands of need.

Liberating the Talents (DOH, 2002) introduced an advanced community practitioner, the Community Matron. These will be trained at an advanced level that includes physical assessment and clinical decision making skills, commissioning and extended nurse prescribing.

The role of Community Matron will be developed to have excellent case management skills along with advanced clinical skills. Skills for Health have identified 53 key competencies for this role. Community Matrons will case manage up to 50 patients with complex, multiple needs with the aim of avoiding unnecessary hospital bed days by 5% (Kings Fund 2006, Public Service Agreement) and supporting patients to be expert in their condition so they know when to call for help. They will also work in partnership with hospital discharge coordinators to facilitate speedy discharge of patients and intermediate care will support this process. Community Matrons will be independent prescribers and be able to order diagnostics. They will work very closely with other primary care professionals, secondary care providers and with social services.

Community nurses will continue to provide nursing care to patients in their homes but will work closely with community matrons and health care support

workers to develop appropriate packages of care to patients and also develop their key worker and health promotion role.

Health care support workers will be an integral part of the community teams taking on new competency based tasks.

The roles of specialist nurses, intermediate care and practice nurses, in providing care for patients, advice and support and communication channels, will be crucial to the success of Community Matrons.

Commissioning Options

1 Community Nurses leading on commissioning services for patients with long term conditions.

In this option community nurses would be involved in purchasing packages of care for their patients.

2 Community nursing roles being commissioned, under Practice Based Commissioning for example.

Here nurses will need to be in a position to provide a contestable, good value, evidence based service. Service outputs and outcomes will be closely monitored by commissioners. This could be nurses working for private companies, charities, local authorities or NHS organisations. (See *Nurse Provider Models Section on page 29*).

3 Nurses involved in commissioning groups, contributing their knowledge and expertise.

These groups will be prioritising needs and services in their local areas. Community nurses and practice nurses are key people in their local areas and will be able to provide insight into the needs of their local population and services that already exist.

Opportunities for nurses:

- To work across traditional boundaries of health and social care.
- Forming and developing partnerships
- Comprehensive case management
- Extended skills
- Autonomy and credibility
- Ability to be involved in developing local services

Benefits for patients

- Prevent unnecessary admissions to hospital
- Reducing length of stay in hospital
- Better health outcomes and quality of life
- Having a case manager therefore only having one person to relate to
- Having tailored local services



Evaluating health care

The primary focus of evaluation is to determine the effectiveness of a service in light of the attainment of pre-set priorities and goals. Evaluation helps document whether a service is accomplishing its goals or not. It identifies weaknesses and strengths and the areas of the service that need revision.

Two popular evaluation models are "Donabedian" and 'Maxwell's 6'.

Donabedian

A fact-based model used for health service evaluation and split into three main areas.

- **Structure** involves evaluating the service provided and whether the organisation is fit for purpose.
- **Process** involves looking at how the service was provided.
- **Outcome** seeks to measure whether the long term goals or outputs were achieved.

Maxwell's 6

Evaluating the quality of care, this model has a more people-based focus and assesses the affects of a service on its users. The six principles are:

- **Effectiveness**
Services can be encouraged to look at evidence of effectiveness in relation to their service delivery, and ensure that this is monitored and evaluated as part of the service level agreement monitoring and future planning. Measuring the quality of healthcare systems especially outcomes is complex. The main data set for such is mortality.
- **Efficiency**
This is usually measured through economic assessment and the least costly, saving money whilst producing the same or increased output. However, cost savings alone cannot be relied upon as an effective measure of quality if services have in fact deteriorated. Likewise administration costs would need to be considered, as budgets will include management time for processing invoices and data collection. Modern methods include performance monitoring and targets. Services should be provided at high quality and at the best value within available resources.

- **Accessibility**

This criteria is concerned with how readily available services are. Specifically this relates to waiting times for admission and out patients. Other criteria could include access to IT, mobile phones for SMS messaging, promotional material in a variety of languages and targeting “hard to reach” groups. Services should be clearly advertised, welcoming and accessible to those who need to use them. They could encompass the needs of diverse communities, and make them accessible to meet those needs, including those for whom English is not their first language.

- **Equity**

Equity with regards to health is particularly complex because a wide variety of factors impact on health (the wider determinants). There is a distinction between equality of access (the extent to which different social groups have access to services) and equality of health status (the extent to which different social groups enjoy similar levels of health). People need access to services of quality, appropriate to their needs, regardless of race, gender, sexuality and religious and cultural beliefs. Services could offer opportunities for significant improvements in health, including reduction in diseases and disorders, and promote wellbeing to all users, applying principles outlined in the health promotion toolkit. Commissioners and providers should recognise the interplay of other social and political factors in relation to population health.

- **Social Acceptability**

This relates to consumer satisfaction of healthcare and methods used to assess this including both positive and negative views. Topics can cover access to services, availability of information, attitudes of service users and service providers including staff etc. Services can encourage and enable users and carers to participate in the life of the community in which they live. Information on and referrals to other agencies, organisations and/or groups in the local area facilitate participation for service users. Where possible, user feedback should be fed into the commissioning process, via service providers.

- **Relevance to Health Needs**

An important criterion because it sets the scene for the appropriateness of services to the specific population and consumer group; to what extent is the healthcare provided appropriate to the patients who receive it? The methodology is complex and success depends on defining the needs of the population.

Clinical Governance

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish. Clinical governance is clearly an important part of evaluation.

For clinical governance to be effective standards must be measurable, achievable, relevant and acceptable. A working definition of clinical governance is the various factors that will influence the development of standards. Clinical governance has five sectors:

- clinical audit,
- clinical effectiveness,
- clinical risk management,
- quality assurance
- staff and organisation development.

DoH, Standards for Better Health states, “The standards apply to the provision of all NHS services in the full variety of settings, including NHS Foundation Trusts, and the voluntary and private sectors insofar as they provide care to NHS patients”.

For further information see www.dh.gov.uk/assetRoot/04/08/66/66/04086666.pdf



Writing a Business Plan

Practice based commissioning provides opportunities for nurses to engage in commissioning, redesigning and providing new and existing services. The NHS operates within increasingly challenging financial constraints and health care services must be able to provide evidence of value for money as well as clinical effectiveness. In order to engage effectively in practice based commissioning, it is important that nurses have an understanding of the process of business planning.

A Business Plan sets out a vision for a new or existing service. It should demonstrate the contribution that the service will make to meet national targets and key local service priorities. A business plan for a new service in health care should include a detailed definition of the service to be provided, the time frame and the key outcomes, including benefits to patients and the public health gain. It should also demonstrate value for money, key stake holder support and the involvement of patients and front line staff. In addition to energy, enthusiasm and self confidence, the nurse entrepreneur will need skills in communication, negotiation, marketing, time management, public relations and accounting skills as well as knowledge of legal, insurance, grants and tax matters.

Suggested template

The following Business Planning template is taken from an e-learning CD ROM produced by the Centre for the Development of Health care Policy and Practice, School of Health care studies, University of Leeds. Although some of the language may be more familiar to entrepreneurs working in commercial environments, the principles are equally important for those working in public service organisations. Business Planning is an important part of strategic planning and financial management in most public service organisations. A business plan provides senior managers and sponsors with answers to the questions that they must ask before investing public money in new enterprises or innovations. Once it has been accepted, a business plan may be followed by a detailed project plan, covering some similar areas, but adopting a more operational perspective

Follow this format to complete a working copy of your business plan:

Cover page: Include details of name of company or service, name of leads(s), address, telephone number.

Executive Summary: Briefly describe your company's product or service, the unique factors that distinguish you from the competition, your marketability and your business objectives. Discuss the management of the business, summarise your financial projections and identify the amount, sources and purposes of the money required for the business.

Table of contents: List and describe the major sections of the plan. Include a brief description of the contents of each section and indicate the page numbers.

Description of Company: Describe your business, the product or service you provide, your potential clients, what specific needs you are meeting, the competitive advantage you have, and your potential markets for the business in the future. Discuss how you will reach customers and how they will reach you. Describe the image your company will have.

Description of Industry: Briefly describe the dominant trends in the industry that are shaping the market for you business now and in the future. List your sources of information.

Market Research and Analysis: This is the first step in business planning and the most critical one: the demonstration that there is a market for your products/services. Indicate your data sources, your specific market segments, the relevant market trends and the size of your markets. Identify your competitors, their current strength, their likely response to you entering the market and the features that distinguish your products/services from theirs. Identify your market geographically. Where will you do business? What is the size of the market? What share of the market will you have? What will you charge? What are your market share projections for the next one, five and ten years? What are your revenue projections?

Marketing Plan: List your marketing goals and discuss the strategies you will use to reach each of your target markets. Identify the persons accountable for marketing; indicate the cost of each strategy and describe how you will monitor emerging markets and evaluate how well current promotion strategies are working.



Management team: Outline the management team. Draw an organisational chart and include a job description from each management position. Discuss the competencies, experience and credentials that each key management person brings to the team. Discuss compensation, ownership privileges, profit sharing and other issues as they apply to key management personnel. If you have a board of directors, describe the expertise that each member brings to the management team and the role that the board plays in the corporation.

Support team: Describe the expert services (e.g. accounting, financial, legal and technical) that you will utilise to develop and maintain a successful business.

Operations Plan: Describe how you will organise the process. Include information about personnel, location, equipment and other essential operational elements. Discuss the work to be done, who will do the work and the time and money required to accomplish the work.

Research and Development Plan: Discuss your plans for research and developments to secure the future of your business. How will you review and evaluate your service? How will you maintain standards and provide quality assurance. How much time, energy and money will be devoted to this effort?

The Overall Schedule: Identify the timetable for critical activities both before and after the start up period. These activities might include locating an office space, hiring personnel, or contacting the first client.

Critical Risks and Problems: Discuss the major risks and problems you face and explain your strategies for dealing with them.

Financial Plan: An accountant is essential to provide financial advice.

Your financial plan should include:

- a company budget with at least one-year projection
- a start up balance sheet and income projection statement
- a cash-flow projection for at least one year
- a budget deviation analysis for each month you are in business
- a break-even analysis

Proposed Financing: Outline your plan for obtaining the necessary financing for the business. How much money will you require and for what purposes? What will you invest? Where will you obtain additional funds? Include a personal financial statement if you intend to find outside capital.

Legal Structure: Describe the legal structure of your business.

Appendices and Supporting Documents: Include any appendices and/or supporting documents here.

Service Level Agreements (SLA)

An SLA is used to formalise the recording of the arrangements between purchasers and providers of services. It includes details of the parties involved, the length of time of the agreement, monitoring, pricing and performance management arrangements. With the exception of Foundation Trusts, these are not legally binding, but are a record of the terms and conditions being worked to by the provider. Appendices are used to create bespoke agreements for specific areas.

User Involvement

The NHS Plan, published in July 2000, aims to make sure that patients and the public have a real say in how NHS services are planned and developed. Section 11 of the Health & Social Care Act 2001 places a new duty on NHS organisations to involve and consult patients and the public and make sure that Patient and Public Involvement (PPI) is a high priority and that arrangements are in place to enable this to happen.

Involving and consulting means discussing with patients and the public their ideas, your plans, their experiences, why services need to change, what they want from services and how to make the best use of resources. It is important that involvement and consultation is adequate both in terms of time and content.

Involving users is not just about fulfilling a duty or ticking boxes. It is about understanding and valuing the benefits and positive outcomes of involving patients and the public in the planning, development, delivery and evaluation of health services. The focus of PPI activity is to engage individuals and specific communities (rather than the population at large) to receive their feedback and to help them influence the design and development of patient services and pathways to improve the performance, relevance and quality of services provided.

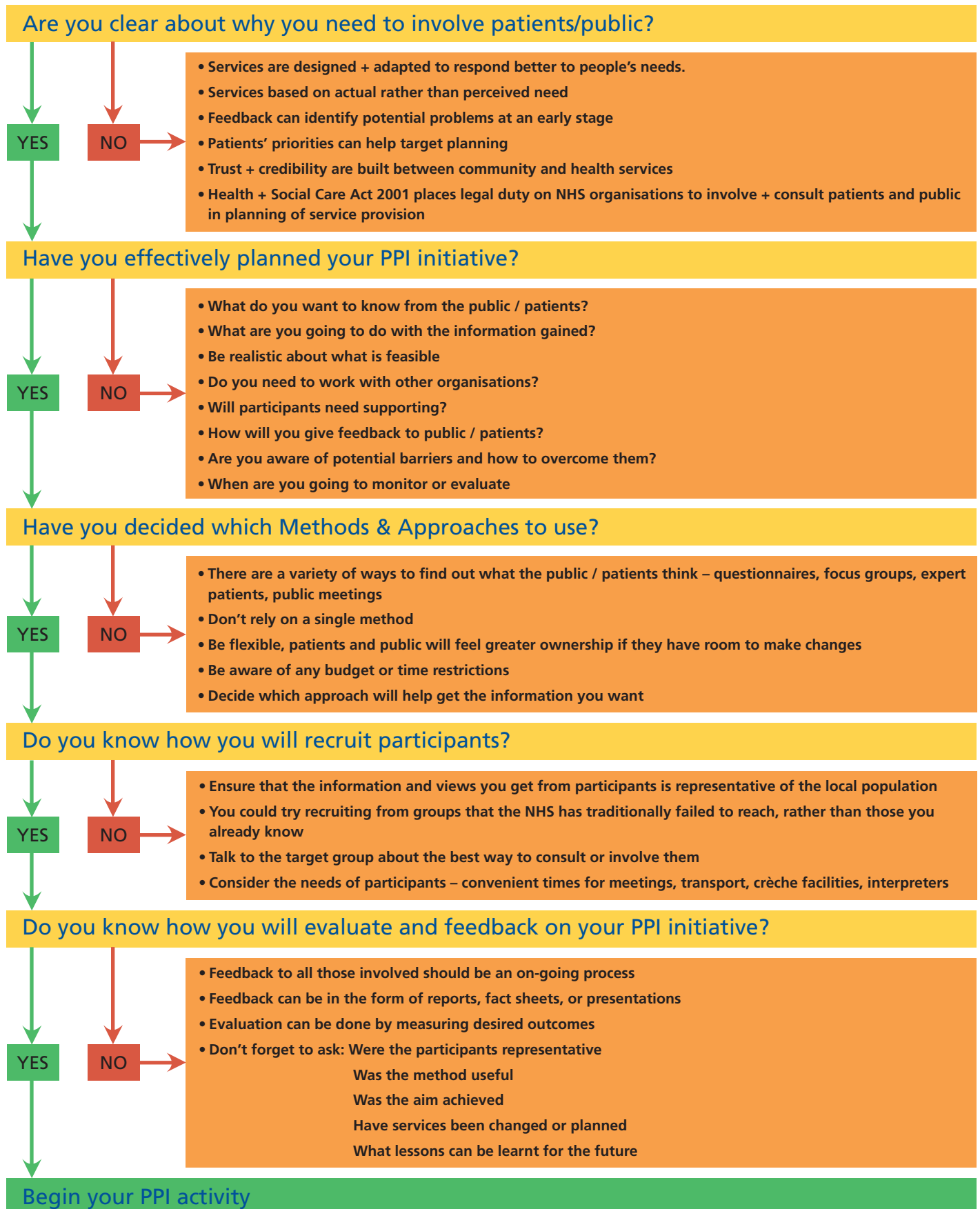
There are many reasons for involvement and consultation:

- Services are designed and adapted to respond better to people's needs
- Participation
- Finding out what priorities patients have will help in targeting service planning and resource allocation
- When patients and the public are well-informed, involved and active in decision making, there are fewer complaints, greater satisfaction with services and more appropriate use of services
- Major decisions are more transparent and the process for reaching them is understood increasing people's sense of ownership of the NHS
- Trust and credibility are built between communities and the health service
- Patients and the public have a right to a say in decisions and policies on how health services are delivered locally

- Patients and the public can set performance standards relevant to their needs and values. This is likely to improve use of health services and increase cost effectiveness. Failure to involve can increase 'inappropriate' demand and lead to services being planned on the basis of perceived need rather than actual need
- Patient and public views, comments and complaints can monitor the effectiveness of services and play a valuable role in the education of health professionals
- Patient feedback can identify problems at an early stage so that they can be addressed before they escalate



How to involve patients and the public – a flowchart



For further information, with ideas for how to access different groups; methods of gaining and sharing information go to www.islingtonpct.nhs.uk/publications/PPI%20Strategy%20Action%20Plan%202005-08.doc

Education and Training

The purpose of this section is to:

- Identify what knowledge and skills you need to effectively engage in the commissioning process.
- Identify who needs education and training and why.
- Identify the types of training and education courses, which may be useful in developing your knowledge and skills.
- Identify other sources of information available to facilitate you to increase your knowledge.

Building on Existing Knowledge and Skills

Many nurses and midwives already have knowledge and skills, which will be essential for effective commissioning such as professional expertise and local knowledge. However for many, they will need to develop new skills in order to move into new roles such as taking on a commissioning role, getting involved in service planning and development or setting up a new health care service.

The checklist below will help you identify the knowledge and skills you already have which will be useful in the commissioning process, and the skills you may wish to develop depending on how you plan to get involved in commissioning in the future.

Knowledge & Skills	Do I already have this?		Comments
	YES	NO	
Understanding of the Commissioning Process			All nurses should have a basic understanding of commissioning.
Health needs assessment (HNA) skills			Most primary care and community nurses have local knowledge which can contribute enormously to HNA. You may want to seek further training to develop your expertise in HNA.
Business skills			All nurses need to become more business orientated to meet the challenges of a more business orientated approach to healthcare. Senior nurses and managers need to use business tools to demonstrate the 'contestability' of their service.
Service Redesign			Practice based commissioning provides opportunities to deliver care in new ways. Senior nurses and managers need to change management skills in order to develop and change the way services are delivered to meet health need.
Strategic Planning			Senior managers and nurses need to be able to plan strategically to ensure services commissioned meet local health care need.
Collaborative Working			Boundaries between health and social care are being eroded as services are jointly commissioned to meet client need.
Entrepreneurial skills			Some groups of nurses may take the opportunity to set themselves up as a commercial business to be commissioned.
User Involvement			This is high on all health and social care agendas. Health care professionals need to actively seek user involvement in decision making about commissioning of local services.
IT Skills			Competent IT skills are vital in modern healthcare – specifically in PBC for collection of data.
Financial understanding/planning			All healthcare workers need a much better understanding of the financial costs of the healthcare they provide and implications of health care choices made. Those in more strategic positions need financial planning skills.

Who needs education and training?

It is clear from above that nurses at all levels need to have a basic understanding of the commissioning process. If we refer back to earlier sections in the toolkit, then many nurses will have a key role in gathering local information, identifying local need or demonstrating the value of the service they provide to local commissioners.

More senior nurses with managerial responsibilities need to develop a more acute business sense and be able to, for example, put forward a business case to provide a service or provide accurate evidence based information to demonstrate the rationale for providing specific care in a particular way.

Other nurses and midwives will see this policy change as an opportunity to move in new directions, for example become a commissioner or set themselves up as a business providing a health care service to be commissioned. In these cases individuals will probably need to develop a wide range of new skills.



Challenges to Education and Training and Impact on PBC

High quality education and training is a cornerstone of successful practice-based commissioning (PBC). This is because it is essential that there are sufficient nurses and other health professionals who are fit for purpose: both to participate in the commissioning process and to deliver the care that is commissioned. It is ironic, therefore, that the viability of future PBC and service provision is at risk as a result of the current state of funding and commissioning for education in nursing, midwifery and the allied health professions (AHPs).

A recent report from the Council of Deans and Heads of UK University Faculties for Nursing and Health Professionals (CoD) reports the following concerns (adapted from CoD 2006 pp 1-2):

- Pre-registration commissions have been reduced by an average of 10% for 2006/07 compared to 2005/06. Much larger reductions have been reported in Strategic Health Authority (SHA) areas in London and South Central, South West and East of England. Several Higher Education Institutions

(HEIs) have reported that their SHAs are predicting further, larger reductions for 2007/08.

- Most HEIs reported reductions in post-registration and continuing professional development (CPD) commissions of a minimum of 10% and are warning of severe reductions in 2007/08.
- Even in areas where post-registration and CPD commissions have not been significantly reduced, HEIs are reporting poor student uptake due to the loss of funding to 'back fill' posts to release staff to attend such programmes.
- The lack of 'back fill' has particularly affected community nursing, with many HEIs reporting large reductions in student numbers leading, in some instances, to the discontinuation of courses.

The effect of these reductions is that there will be less students qualifying on pre-registration programmes in the next 3 years as well as fewer possibilities for existing qualified staff to develop their competencies. This presents a challenge in meeting the aims of a modernised NHS, which will require a highly skilled workforce to provide quality care in complex environments. Nurses and other health professionals must take an active role in PBC to ensure that there are appropriate education and training opportunities to meet both their needs and the needs of their patients.

Identifying your own education and training needs

There are two main avenues to explore to help you identify your own specific training needs around commissioning;

- Personal Development Plans (PDP) with your line manager
- Using Skills for Health Self Assessment Tool

Personal Development Plan

Your line manager should be offering you a regular opportunity to meet for an appraisal and to identify your personal development plan (PDP) linked into the KSF. This will help you identify specific areas you may want to develop, how you are going to develop them and what resources are required for you to do so.

Use of Skills for Health Self Assessment Tool

Skills for Health works with employers and other stakeholders to ensure that those working in the health sector are equipped with the right skills to

support the development and delivery of healthcare services. They offer a self assessment tool which allows you to measure your level of competence against a particular role profile (for example in public health or case management). The results are saved and you can re-take the assessment to see the development of your skills over time.

To find out more log onto their website

www.skillsforhealth.org.uk

Education and Training

Once you have identified the gaps in your knowledge and skills there are a range of resources you can use to address this. These include the following:

Your Employer

Ask your line manager if there are in-house courses or study days that you can go on. Some of the skills needed are 'generic' skills and therefore, in-house courses are available – for example IT skills. You may not be the only one wanting training in a specific area and your request may result in your manager organising something in response.

Local University or College

Contact your local university or college to find out what courses or study days they have to meet your specific needs. A good place to start is the health or nursing department who will certainly run a range of practice/clinical courses– for example courses on public health or courses to prepare nurses to be community matrons. A list of universities offering nursing courses in the London area is given in [Appendix 3](#).

However, the courses needed for you to become more effective in participating in commissioning may not be provided by the health department. You maybe better off looking at what business or management courses are available in your local college or university. Many institutions do run specific management courses for health care professionals and colleges and Universities are responding to the need for more 'business' orientated health care professionals by developing short courses in this area. It is probably worth contacting the departmental head for post-registration nursing courses who may be able to point you in the right direction.



Other sources of Information

Websites

Department of Health Website

www.dh.gov.uk

The Department of Health Website is invaluable source of up to date information about current health care policy.

Primary Care Contracting Website

www.primarycarecontracting.nhs.uk

The site brings together information and resources to help you understand and implement the new primary care contracting arrangements.

Kings Fund Website

www.kingsfund.org.uk

The King's Fund is an independent charitable organisation working for better health, especially in London. The website is a useful source of articles commenting on health policy and service provision.

Queen's Nursing Institute (QNI) –

www.qni.org.uk

Much of the professional activity of the QNI focuses on the future role of nurses in primary care, and we work to influence policy relating to community nursing in the new National Health Service agenda. The site has briefing papers on PBC, community matrons and nurse partners.

Journals/ Articles

Clearly another good source of information are articles in journals such as the Health Service Journal and Independent Nurse.

External Conferences

There are a number of external conferences available on commissioning though they do tend to be expensive (e.g. HSJ conferences).

Professional Organisations

Some professional organisations such as the RCN are offering study days and short courses relevant to commissioning.

Useful websites and Resources

Useful websites and Resources

Department of Health and related websites;

www.dh.gov.uk

www.primarycarecontracting.nhs.uk

www.nice.org.uk

www.skillsforhealth.org.uk

www.natpact.nhs.uk

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/fs/en

www.londonhealth.gov.uk

Kings Fund

www.kingsfund.org.uk

NHS Alliance

www.nhsalliance.org

National Association of Primary Care

www.primarycare.co.uk

Other resources

RCN (1997) publication number 000729. *Turning initiative into independence: information for would-be nurse entrepreneurs*

The Social Entrepreneur. Developing Enterprise Skills for Public Service. Interactive e-learning CD-ROM produced by the Centre for the Development of Healthcare Studies, University of Leeds.

Appendix 1

THEIMM – a framework used for looking at the resources available within an organisation.

T	Time	Is it the right time to do this piece of work / set up this service? Are their other competing priorities? Do you have the time to complete this work? Does the current climate support this work at this time?
H	Human	Do you have the right people available to undertake this piece of work? Do they have the right skills? Who else needs to be involved?
E	Equipment	What hardware are you going to need? Do you need equipment or machinery to set up this service?
I	Information	What information is already available to you? What further information are you going to need?
M	Materials	What consumable materials are you going to need to do this piece of work effectively?
M	Money	What are the financial implications for this work? What are the proposed costs?

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Appendix 2

Developing Nursing to Transform Primary Care

Paper by Nicola Walsh (for DH Strategy Unit) May 2005. (nicola.walsh7@btinternet.com)

Issue

Models of primary care delivery in England have remained fairly constant for decades; centred around General Practitioner independent contractor based practice. However, there are many changes taking place; the profile of the GP workforce; the expectations of the public are also changing in terms of their own lifestyle, life expectancy, and also expectations of service; and the profile of the nursing workforce is also changing. This paper outlines key features of some of the challenges and opportunities in primary care, and proposes a number of alternative models for provision that has a different locus of control.

Summary and main points

- The pool of primary care providers could be enlarged through the development of nurses.
- Extending the number of nurse-led provided first contact services using pharmacists, children's centres, schools and other community facilities would provide increased access and choice.
- Extending the number of nurse run practices and nurse partners would start to offer real choices to patients, both in terms of increasing capacity and offering alternative models of practice.
- Patients with long-term conditions could benefit from community based specialist teams that bring together hospital out-reach nurses, community matrons, district nurses, and others.

Developing Nursing to Transform Primary Care

1 Introduction

1.1 In the United Kingdom, we have traditionally had a cost effective primary health care system provided predominantly by general practice (De Maeseneer et al 2000). This model of service has enabled service innovation in ways that a centrally directed service may have found difficult to achieve but it has also led to problems that need addressing such as:

- an inequitable distribution of practices especially in areas of deprivation;

- varying quality standards;
- little or no choice of primary care provider for patients; and
- services that tend to be a “one size fits all” model (a family doctor service) which may no longer meet the needs of different groups of patients with specific needs

1.2 The notion of a GP principal working full-time in a practice for all of their working life is no longer the dominant model. The GP workforce is rapidly changing. One in three GPs are female, more GPs are working part-time, and more are working in non-principal posts. Many GPs are also taking up opportunities to diversify developing a specialist clinical interest or getting a part-time teaching or management post. These trends are set to continue and the new primary care contracts support this more flexible working pattern. This means that if GPs remain the first point of contact there will not be enough GPs to meet the growing demands of the service and patient expectations. Recruitment difficulties in some areas have already led to changes with increasing numbers of nurses becoming involved in first contact care. How therefore can primary/community based nursing contribute to providing a more flexible and responsive primary care service?

1.3 This paper sets out some potential nursing models which could deliver alternatives for patients and also meet wider government objectives such as:

- improving patient access and choice;
- building capacity by organisations and professionals working together to the benefit of their community;
- promoting a greater focus on health and well-being;
- increasing clinical engagement in the commissioning of healthcare services; and
- improving health outcomes

The paper is divided into four sections. Section 2 reviews the evidence on doctor-nurse substitution in primary care in relation to patient outcomes, cost, workload and patient experience. Section 3 sets out 10 potential nursing models for the future and the final section lists the actions required

to support such changes. (Annex 1 outlines the current position of the nursing workforce in primary and community care in England)

2 Evidence Base

2.0 One way of describing the activities of primary care nurses is to consider them as two groups: doctor supplements or doctor substitutes. Nurses working as ‘doctor supplements’ provide services which complement or extend those provided by doctors. In contrast, nurses working as ‘doctor substitutes’ provide services which otherwise would be provided by doctors. If community based nurses are to strengthen capacity in primary care services and be in the vanguard of providing alternative more responsive services we will need to expand the number of nurses working as doctor substitutes. This section reviews the evidence on doctor-nurse substitution in primary care in relation to patient outcomes, cost, workload and patient experience.

2.1 Patient outcomes a Cochrane Review (2005) on the impact of doctor-nurse substitution in primary care concludes that ‘appropriately trained nurses can produce as high a quality of care as primary care doctors and achieve as good health outcomes for patients’ (Cochrane 2005 p.20). Indeed, nurses providing first contact care for patients needing urgent attention tended to provide more health advice and achieve higher levels of patient satisfaction compared to doctors. The authors divided the 16 studies into 3 categories as displayed below in box 2.1.

2.2 Other reviews conducted in this area show similar findings: nurses generally achieve outcomes as good as doctors but nurses have longer consultation times, carry out more investigations and may recall patients at a higher rate (Sibbald et al 2004; Horrocks et al 2002).

Box 2.1 Impact of Doctor-Nurse Substitution in Primary Care

- In 7 studies the nurse assumed responsibility for first contact and ongoing care for all presenting patients. No appreciable differences were found between doctors and nurses in health outcomes for patients, process of care, resource utilisation or cost.
- In 5 studies the nurse assumed responsibility for first contact care for patients wanting urgent consultations. Patient health outcomes were similar for nurses and doctors but patient satisfaction was higher with nurse-led care. Nurses tended to provide longer consultations, give more information to patients and recall patients more frequently than did doctors. The impact on physician workload and direct cost of care was variable.
- In 4 studies the nurse took responsibility for the ongoing management of patients with particular chronic conditions. In general, no appreciable differences were found between doctors and nurses in health outcomes for patients, process of care, resource utilisation or cost (Laurant et al 2005).

2.3 Cost doctor-nurse substitution has the potential to reduce direct healthcare costs but this depends on the salary differential between doctors and nurses, and these may vary across locations over time. In addition, savings on nurse's salaries may be offset by nurses' longer consultation times with the patient and an increased rate of patient recall relative to doctors, leading to no overall savings in cost (Sibbald et al 2004; Cochrane 2005). It should be noted that patient follow-up in many studies is 12 months or less. In a two year study conducted by Sharples et al (2002) looking at services provided by doctors and nurses in clinics for the management of chronic respiratory disease the costs of doctor led care remained steady, while the costs of nurse-led care reduced. The reduction in nurse led care costs is suggestive of a learning curve for the nurses. This may be the case in other instances. Further research about the cost-effectiveness of nurse-led care in primary care is needed.

Evidence suggests that most patients place great importance on the interpersonal aspects of care and that these have a significant relationship to outcomes, including patients' adherence to medical advice. The fact that nurses score highly in this area in the long term may be more cost effective. From the perspective of the healthcare economy as a whole, it is generally cheaper to train nurses than it is to train doctors; but savings are eroded as nurses to date have currently had a lower lifetime workforce participation rates compared to doctors. Cost savings are therefore highly context dependent (Sibbald et al 2004; Horrocks et al 2002).

2.4 Workload and roles nurse-doctor substitution in primary care has the potential to reduce doctors' workload. Doctors' workload may however, remain unchanged either because nurses are deployed to meet previously un-met patient need or because of new styles of engaging patients, generate demand for care where previously there was none. Gains in service efficiency may be achieved if doctors give up providing the services now being undertaken by nurses. If doctors and nurses are both to practise at the upper end of their skills changes will need to be managed (Sibbald et al 2004). Evidence from first and second wave nurse-run PMS pilots revealed degrees of role overlap between the doctor and nurse. However in sites where GPs and nurses spent time reflecting together on what they were trying to achieve and sharing an understanding of their professional issues and competencies, they were able to capitalise on their different strengths – thus providing a different model of care (Walsh et al 2003).

2.5 Patient experience to date, patients' satisfaction surveys on nursing care demonstrate improved patient satisfaction and quality of care related to patient education, communication and documentation (Cochrane 2005; Horrocks et al 2002). High satisfaction with a nurse however does not mean that patients inevitably prefer nurses to doctors. Nurses may be preferred when the patient believes their problem to be 'minor or routine' but doctors are preferred when the problem is thought to be 'more serious' (Cochrane 2005).

2.6 Further research most studies have compared a nurse practitioner with physicians in their ability to improve patient outcomes associated with medical care (Spitzer et al 1974, Munding et al 2000, Horrocks et al 2002). As a result, less is known about the impact of nursing care. Further research is needed on the impact of the non-clinical aspects of nurse roles upon patients, the longer term health gains achieved by nurses and their impact upon other services.

3 Potential Nursing Models for the Future

This section sets out ten potential models for consideration. This is not an exhaustive list but gives a series of options for discussion about the future provision of primary care nursing services.

3.1 Model 1: Nurse-run practice

In a nurse-run practice, the nurse acts as an independent contractor employing other staff (including a GP) to support them in providing a comprehensive primary care service to a registered population (tier 2 – see [Annex 3](#)). The patient is seen by the most appropriate person to help them with their problem. This is determined by the nurse who is the first point of contact for the patient but choice is given to the patient (Baraniak and Gardener 2001). The nurse owns or rents the premises and takes on responsibility for the practice. Nurses in this model order diagnostic investigations such as X-rays and refer patients directly to hospital consultants. In many instances, there are no formal procedures and acceptance is reliant upon the relationship between the nurse and the hospital consultant. These nurses could also opt to hold a budget and commission services on behalf of their population.

Organisational form could be a professional or limited liability partnership or a limited company. In the example below, the two nurses have set themselves up as a company limited by guarantee and an alliance has been established with a local social enterprise organisation to provide financial management and business systems.

Contracting mechanism a PMS contract is used thereby requiring no GP signature on the contract. The organisational form would determine whether PMS or APMS is used.

Box 3.1 Example of a Nurse-run Practice

A practice covering a population of 5,000 is taken on by two nurse practitioners. They secure two GP sessions a day from the local PCT Provider Unit. They also employ a practice manager, two part-time practice nurses and a healthcare assistant. They establish themselves as a company limited by guarantee that is owned by a large locally based social enterprise organisation (BLT) with a turnover of £25m and over 650 employees. The business of the practice is overseen by a board which comprises of the two nurse practitioners, the practice manager and a business development manager from BLT. The board meets monthly to review financial and performance information prepared by BLT. Day to day decisions are taken by the management team (one nurse practitioner and the practice manager). The management team have responsibility for commissioning an agreed level of services for their registered population. Any surplus made from the sale of the property will be re-invested back into the practice budget.

Evidence evaluation studies of the nurse-run PMS practices show that they can provide a safe and acceptable alternative for patients. In contrast to many GP-led practices, nurse-led practices tend to adopt a more community oriented approach in their planning and delivery of services (Roe, Walsh and Huntington 2001; Lewis et al 2001). There is also evidence that patients served by nurse-led practices are more involved in decisions about care and treatment. (Lewis 2001). One nurse in the West Midlands is working closely with a business manager and is now successfully running 3 practices across 2 PCTs. Managers at the PCTs claim that these different types of practice have had a 'positive' impact upon local services.

Barriers recruiting nurses to act as independent contractors has proved difficult and although this model has been available since 1998 there are only 4 such practices in UK (personal communication). A range of barriers preventing expansion of the model have been identified and

include: resistance and hostility from local general practice, GP domination of the PCT Professional Executive (PEC), a reluctance by some PCT staff to challenge local general practice and in some cases a lack of knowledge amongst managers (and others) about the various contracting mechanisms. Regulatory limitations include authority to prescribe, to sign certificates and liability status. Some of the nurses who have taken over the running of a practice have also reported difficulties accessing finance to purchase premises.

3.2 Model 2: Nurse-led primary care services

Nurse-led primary care services for specific population groups such as asylum seekers, travellers, or homeless people. These groups are often poorly served by general practice and often not registered with a practice. In this model, the nurse collaborates with other health and social care professionals including a GP to provide a comprehensive range of services. This model would fit between tiers 1 and 2 ([Annex 3](#)).

Box 3.2 Example of a nurse-led primary care service

A nurse-led service for teenagers. The service would employ a primary health care nurse who would hold four sessions per week across two centres and provide case management for teenagers with complex needs. The primary care nurse will do additional work such as supporting school based clinics, health promotion projects, outreach clinics and home visiting. There will be referral and follow through from this service to secondary care services facilitating a smoother transition and less unnecessary use of specialist services.

Organisational form the nurse (and other support staff) could be self-employed and have a contract with a local primary care provider or directly with the commissioning body. Alternatively, the nurse may be an employee of a local primary care provider.

Contracting mechanism the organisational form would determine whether or not a PMS, APMS or PCTMS contract is used.

Evidence many of the existing nurse-led PMS primary care services are located in areas serving populations that have previously been marginalised from mainstream health services. Research studies show that these services have provided a successful and acceptable alternative for patients. Again, they have tended to develop a more community-oriented approach in the planning and delivery of services. In some instances, these nurses have developed close links with the communities they serve and successfully secured additional community resources (Lewis et al 2001). Recruiting nurses to provide such services has proved easier than option 1 but again the numbers of such schemes are low.

Barriers similar to model 1. Resistance from local GPs and inadequate knowledge (and use) of new primary care contracts. Regulatory barriers such as prescribing medicines, signing certificates and referring patients to hospital consultants (in some areas) also hindered nurses from fulfilling their roles. There were also issues around liability status.

3.3 Model 3: Multi-disciplinary professional partnerships

Nurses as “partners” in multi-disciplinary partnerships (as opposed to GP partnerships) would start to offer real choices to patients, both in terms of increasing capacity and offering an alternative model of practice. Nurse partners are not necessarily new but changes in funding through the new primary care contracts has made it easier for GPs to take on nurses and others as partners. This would be tier 2 ([Annex 3](#)).

Box 3.3 Example of a Multi-disciplinary Partnership

Five partners covering a population of 11,000 in an affluent area. In the partnership there are 2 GPs, 2 nurses and a practice manager. All of the partners are full equal sharing partners and take a lead responsibility in the practice. One nurse partner takes the lead in quality and clinical governance, the other has the lead for commissioning and works closely with the practice manager.

Organisational form – a professional partnership. A nurse could become a salaried partner, a fixed share or full equal partner. A salaried partner continues to be employed as a staff member, so taking on none of the risks of a full partnership but receives an agreed part share of the practice profits in addition to regular remuneration. A fixed share partner is self-employed and receives an agreed, fixed share of practice profits. A full equal partner is self-employed and part-owner of the business with the other partners. Full partners have unlimited liabilities of the business.

Contracting mechanism a professional partnership could use a PMS or GMS contract. They may also sub-contract for services through a SPMS contract. For example, they may contract with a self-employed nurse to provide sexual health services to people not registered at the practice as well as their own registrants.

Evidence multi-disciplinary partnerships are proving to be a successful model (Roe et al 2001). Discussions held with a group of existing nurse partners identified that nurses occupying these positions are motivated by the greater job satisfaction and autonomy it gives them (similar to models 1 and 2). Interest amongst nurses about becoming a partner is growing. Over 200 nurses attended two recent events on the topic. GP and nurse attendees wanted more information on the financial and legal aspects of nurses becoming partners as well as access to advice on insurance and liability issues.

Barriers existing nurse partners report that the current NHS environment is not supporting nurses wanting to take up this option. There are issues such as NHS superannuation and pensions that need to be clarified. Some nurses keen to explore this option have been prevented from doing so by local GPs. Others, have found it difficult to find out where there are partnership vacancies. Few practices specifically advertise for nurse partners and the nursing journals do not advertise partnership vacancies. In the course of this work, some nurse partners have come together to form a Group under the auspices of the Queen's Nursing Institute to offer more information and support to nurses wishing to become partners (www.qni.org).

3.4 Model 4: Limited Companies

An increasing number of GP partnerships providing an enhanced range of services have set up a limited company to oversee this element of service. A suitably qualified nurse could become an Executive Director of such a company. This would offer nurses a position to influence the strategic direction of the business.

Organisational form a limited company could provide a full or partial range of services to a registered or/and unregistered population (Tiers 1,2 or 3).

Contracting mechanisms the type of limited company would determine whether or not a GMS, PMS or APMS contract is used.

Evidence nurses who have taken up this option have suggested they have similar gains to becoming a partner but fewer risks. They have opportunities to influence the delivery of services, greater financial rewards but none of the risks associated with running your own business. As Executive Directors in the company they report to the partners.

Barriers these positions are not openly advertised, GPs appear to invite nurses to take up these positions once they have worked in the practice and are confident with their work and level of expertise.

3.5 Model 5: Multi-Speciality Teams

Patients with long-term conditions could benefit from community based specialist teams that bring together hospital out-reach nurses, community matrons, community nurses, AHPs and physicians. A commissioning budget could be held by the team for a particular client group or locality. These teams could also be commissioned to discharge patients early and transfer their care to the community. This model would potentially expand the range of services offered by nurses and others working in the community and improve access to care and patient choice.

Organisational form this could be a limited company, a mutual or a limited liability partnership (see Annex 2). Such a team would work with tiers 2 and 3.

Contracting mechanism this will depend on the nature of the service being provided and the legal organisational form adopted.

Box 3.5 Examples of a Multi-Speciality Team

A virtual practice for the frail elderly led by a community matron working with a care manager, therapist, pharmacist, GP with specialist interest or/and a geriatrician. The matron holds the commissioning budget for this group of patients.

Another team focuses on mother and baby services. In this team there are health visitors, midwives and qualified nurses working together with a part-time obstetrician

Evidence Such a model would build on the experiments with multi-speciality teams under PMS 'plus' pilots whereby hospital and primary care staff worked together in the community setting (Lewis et al 2001; Walsh et al 2001).

Barriers the development of PMS Plus services in some areas did encounter difficulties. Hospital managers fearful of the loss of income in some cases prevented consultants from working out in the community. Incentives will need to be introduced to prompt hospital and primary care staff to work together.

3.6 Model 6: Co-located nursing services

In future, nurses could be located in community facilities close to home or work such as pharmacists, children's centres or schools. This would increase patient access and offer choice of provider. It could also potentially forge different ways of working and different relationships between professionals and local communities.

Organisational form a nurse could be self-employed or an employee of another primary care provider or possibly an employee of the community facility.

Contracting mechanism this is most likely to be SPMS.

Evidence The ability for children, especially adolescents and those with complex needs, to access care services at school has the potential to improve access to care significantly. In the United States, there is a high degree of acceptance of school based health care services among children and adolescents (Burstin & Clancy 2004).

Barriers a lack of co-ordination and collaboration with other community and primary care providers has been identified as a potential problem in this model (Showstack et al 2004).

3.7 Model 7: Primary Care Nursing Teams

Such teams could either work independently in free standing or self managed units, or be employed by a primary care. Integrated and specialist nursing teams could provide services to a range of people such as the house-bound, residential and nursing homes, schools and other community facilities. Potential benefits of such services would be improved uptake of health care services, improved overall co-ordination of patient services (health and social care) leading to improved patient satisfaction and outcomes.

Organisational form a self-managed team could coexist in a range of different organisational forms. The organisational form of an independent nursing team would be determined by who is being served and the capital needs of the service.

Contracting mechanism this would be determined by the organisational form adopted and the type of service being provided.

Box 3.7 Integrated Nursing Teams PLC

A small group of nurses set themselves up as an independent body to provide IV therapy to patients in their own homes. SPMS contracts are held with the local hospital, some GP practices and 2 alternative local primary care providers.

A team focusing on the health needs of a deprived population providing first-line health improvement and preventative services. The service would provide self-referral clinics for up to 30 hours per week and would be conducted from a base clinic and a local secondary school. It would provide triage and treatment of minor injuries, diabetes and asthma patient care, wound management, counselling, sexual health consultations, health maintenance checks such as blood pressure, cholesterol testing and cardiac risk assessment.

Evidence Integrated nursing teams could exist in many different forms. A small number of independent nursing teams operate in New Zealand. One is a 15 year old company owned and managed by a nurse with advanced practice competencies and business expertise. This practice employs a staff of eight (5 WTE) to provide a mix of sexual health, women's health and health promotion services to a client base of about 12,000 people. The skill mix includes nursing, medicine, education and counselling, complemented by business management, marketing, communications and financial expertise.

Screening, assessment and treatment services are available in sexual health and women's health. Practice income is derived from a Ministry of Health contract and client fees for screening and courses attended. The limited company also generates income by providing occupational health services to a nearby company of 200 employees. This team is actively promoting health and wellbeing such a model would suit some population groups (www.inp.co.nz).

The evidence reviewed shows that there is widespread agreement on the characteristics of an effective primary care nursing team. A notable by-product of integrated team working is an increase in multi-professional education, which often helps to break down barriers.

Barriers Informal discussions would suggest that we will need to create a climate which enables and supports such developments as the New Zealand model. This would include providing nurses with information about where they could access legal and financial advice. Safeguarding pension rights particularly of experienced community nurses would also be important. We would also need to shift the culture and mindsets of individual nurses and some PCT organisations. One PCT in Surrey is currently re-structuring itself as a commissioning body and separating out their provider functions. The community nursing staff are exploring the possibility of setting themselves up as an independent company. The first step was to give all nurses some clear legal and financial advice about the range of different organisational forms available to them.

3.8 Model 8: Limited Liability Partnership (LLP)

A LLP is a written agreement similar to a partnership agreement used in traditional professional partnerships. The difference is that this is registered at Companies House. Since, organisations can also be members of an LLP, a patient organisation or an independent nursing team could be included as a member of the LLP.

Box 3.8 Example of LLP providing primary care services

There are 10 nurse practitioners working with 4 GPs covering a population of 20,000. Day to day management of the partnership rests with an appointed executive team. The partnership employs a Paediatrician and a Geriatrician on a part-time basis. Administrative services are centralised. Partners and employees draw a monthly salary. All employees are eligible for a share of the profits at the end of the year. This potentially would provide incentives in the development of multi-disciplinary teams. And staff, who wish to become a partner, can do so automatically after two years.

Organisational form a limited liability partnership. Tiers 2 and 3.

Contracting mechanism this would be determined by the level and range of services being provided.

Evidence no literature or case study material has been found but a PCT in Yorkshire is considering using this option.

Barriers similar to model 3 but fewer.

3.9 Model 9: Nursing Co-operative

A coalition of nursing groups or practices formed around a geographical area, a client or disease group could come together to form a co-operative. The key purpose would be to co-ordinate and integrate primary care nursing services across an area. A Nurse Co-ordinator would be appointed to manage the services with financial and administrative support. Contracts could be placed with the co-operative from local commissioning bodies, other local providers and the LA.

Box 3.9 Example of a Nursing Co-operative

Home Nursing Co-operative Services is owned and managed by its nurse members. They provide general nursing services to people in their own homes. It is an independent not-for-profit making limited company. There is a management board made up of four nurse directors representing four localities. They meet with the manager each month to oversee the finances and performance management targets. A 16 member council which includes patient representatives and other clinicians from each of the localities meet quarterly to set the strategic direction. The Co-operative also consults its members via email every three months. The co-operative receives the bulk of its income from local PCT and Local Authority contracts and some service charges. Any surpluses are reinvested in a number of subsidiary social enterprise businesses to provide additional services for members and patients which in turn can bring in extra income. These include a GP service and a walk-in centre service.

Organisational form a co-operative (see Annex)

Contracting mechanism this would be determined by the level of service to be provided.

Evidence from the literature, no such model has been found for nursing services but there is plenty of literature available on the experiences of GPs setting up co-operatives in the early 1990s to provide out of hours services.

Barriers potential 'strait-jacket' thinking by commissioning bodies and a lack of incentives for nurses to develop a new model of service.

3.10 Model 10: A Nursing Chambers

In this model self employed nurse consultants or nurse practitioners join a 'chamber'. Depending on the size of the 'chamber' they may also be provided with 'junior' staff support. Self employed nurses based in such a model could provide a range of services in collaboration with hospital consultants (and others) working across organisational boundaries or solely in a community setting. There is potential with

this model for nurses (and others) to have an important role in working across organisational and professional boundaries. The service would need to be accredited not the institution. Patients would potentially benefit by receiving more specialist care in a community setting.

Box 3.10 An example of a Nursing Chambers

Ten self-employed nurses work in a nursing chamber. There are 3 clinics on site but most work is done in the patient's own home or local community facilities. Each nurse has her own office-base, lap-top and mobile phone. Two of the nurses in this chamber provide specialist children's services and have been commissioned by the local teaching hospital to discharge children early and transfer their care to the community. They are providing a total episode of care. Other nurses in the chamber provide specialist neurological care with input from a local neurologist.

Organisational form self-employed but using chamber facilities and in some cases working with others from the chamber (internal referrals).

Contracting mechanism nurses could work exclusively for one provider or they could have contracts with a range of different providers. In this scenario it is most likely a SPMS contract would be used.

Evidence no example of such a model has been found in the literature to date.

Barriers as with model 9.

In summary, models 1 to 3 already exist in England, however the numbers are small and the nurses working in them have had to be highly resourceful and innovative. They have also handled uncertainty and taken calculated risks. Models 5 and 6 are dependent on the collaboration of different organisations both in and possibly outside the NHS.

Currently, separate nursing disciplines often work in isolation from each other within specific contractual boundaries, although they may serve the same population groups, individuals, families or communities. This limits opportunities for collaboration or developing an integrated approach to service delivery. The establishment of models 5,7,8,9 and 10 would remove such

constraints. The setting up of stand alone or independent nursing teams (model 7) for example, will enable different nursing disciplines and other healthcare professionals to work towards shared goals. This will require in many instances a shift in organisational culture and individual mindsets. Models 8, 9 and 10 will need to be 'road-tested' and the lessons from such experimentation captured and disseminated widely.

4 Solutions and Recommendations

This section sets out the actions required to allow models outlined above to flourish.

4.1 Barriers to change as the previous section has shown there are regulatory, institutional and environmental factors inhibiting change.

Regulatory prescribing, certification, insurance and liability status of nurses taking on new roles, and NHS superannuation and pension rights for nurses acting as independent practitioners.

Institutional amongst the medical profession there is a degree of reluctance to support nurses who are taking on new expanded roles in primary care. For example, hospital consultants in some instances are refusing to accept referrals from nurses. The nursing profession (nationally and locally) has also been reluctant to support nurses taking on new expanded roles in primary care.

Environmental to support new and innovative models of primary care nursing, the NHS environment will need to be more enabling so organisations and individuals can change their operating style. The market entry of new providers will also need to be supported. Currently, the introduction of new primary care providers can only occur if there are problems with GP recruitment, or if a GP practice chooses to opt out of providing certain services or the PCT believes quality standards are not being met. Rules of engagement and regulation of the market will need to be determined at a national level.

4.2 Motivating factors we need to identify what motivates nurses to take on innovative roles as well as barriers to change. The most significant motivator for many of the nurses adopting new roles in primary care is that of securing greater autonomy within which to develop and extend

their practice. Other motivating factors include greater flexibility, and increased control over their work and lives. Traditionally, nurses have valued the flexibility of community nursing services and the increased opportunities to work part-time. Some are also attracted to working in smaller organisations and being able to make a difference more directly.

4.3 Recommendations if we are to create and support community based nurses to work in different ways a number of changes need to happen at both a national and local level.

- At a national level, the immediate task is to grow a larger cohort of 'entrepreneurial' community based nurses to ensure a change in attitude amongst nurses and others working or with the NHS. Some people are natural entrepreneurs, but appropriate training and development can be helpful. Others have the potential to be entrepreneurs, but their talent needs to be nurtured. We might describe them as latent entrepreneurs. Current education and training programmes for nurses (pre and post-registration) do not necessarily support entrepreneurial behaviour.
- In the course of this piece of work a programme has been commissioned by the Department of Health for 15 nurses and AHPs. The overall aim of this programme is to develop participant's entrepreneurial capabilities. Fuller details of the programme are outlined in Annex 4. It is hoped that if this programme is successful it will be repeated annually for a further 2 years to grow a larger cohort of nurse entrepreneurs. These individuals will provide much needed role models for the profession, the medical profession, and the public and policy makers. In time, this cohort of nurse entrepreneurs will be able to offer support and mentorship to other nurses. Dependent on the evaluation of the programme, further cohorts may need to be commissioned.
- An environment needs to be created that nurtures and supports nurse entrepreneurs. We need to encourage PCTs to support innovative risk taking behaviour.
- We need to stimulate people's imagination and market different models through events,

publications and workshops specifically aimed at nurses and others working in primary care.

- Promote and expand the number of nurse-run practices and nurse-led primary care services.
- Promote and expand the number of nurse partners.
- Promote and support the setting up of independent alternative primary care providers by funding a national APMS and SPMS pilot programme. These pilots will act as 'change agents'.
- A national multi-disciplinary development team could be established to support changes in organisational culture. Pilot sites in the national APMS and SPMS programme could be supported by such a team.
- Legitimise social enterprises as part of nursing and the NHS system and make it a reality nurses can identify with.
- Reward current and future nurse entrepreneurs through awards and scholarships. Work with various universities to develop supportive programmes for nurses and others working in the NHS.
- Many of the barriers identified in this paper stem from the way in which the nursing profession is socialised into patterns of work and behaviour during their education and training. We currently have an experienced community nursing workforce which we need work in different ways by using incentives. However, in the longer term we will need to grow a skilled and educated workforce that is able to operate at an advanced level earlier on in their careers. This will require a reconsideration of current education and training programmes.
- In the US, some Schools of Nursing have designed courses to nurture independent practice in primary care. Such new programmes could be developed in the UK to attract a different group of people into nursing.
- We need to engender a culture where nurses in senior positions within primary care organisations talent spot, support and nurture individuals. They will need to work across titles and positions. Such roles need to be developed as part of the career pathways for nurse and midwives with specialist or consultant roles, perhaps as a next career step
- NHS Pension regulations have recently been amended to enable those GPs and nurses who are eligible for an NHS pension to stay within the NHS pension scheme if they set up as an APMS provider. More needs to be done to promote these changes to NHS staff.
- Insurance cover - if we do create opportunities for models to emerge where one GP is working with 10 advanced primary care nurses covering a population of 20,000 who takes responsibility if something goes wrong? Insurance is an issue. Companies such as the Medical Defence Union (MDU) and the Medical Protection Society (MPS) are currently providing insurance indemnity to nurse partners. Nurses are being asked to pay £400 per annum whereas a full-time GP pays around £4,000 per annum. This would suggest that the insurance companies have not yet caught up with the full implications of these changes. The BMA liaises with organisations such as the MDU and MPS but for nurses (as yet) there is no such body. Hold discussions at a national level with insurance companies.
- Nurse Prescribing – this is currently being reviewed. To grow a larger cohort of nurses operating at an advanced level in primary care we will need more nurse prescribers with access to the full formulary.
- Business acumen - nurses taking on leading roles in primary care have found it useful to have a degree of business acumen or/and work closely with an able manager. Repeated studies have shown that the successful 'pairing' of clinical and managerial skills is a key ingredient in implementing change.
- Should nurse led services have incentives (and if so by whom) at this early stage in order to balance the potential inequalities of the 'market'
- Nurses are not currently on the PCT performer list and it would be symbolic to get nurses who run practices i.e. providing primary care services to a registered population to be added to the performer list.

- Language in future press briefings, policy documents and guidance should support and promote new innovative models in primary care as opposed to reinforcing the traditional 'family doctor' model.
- Consideration needs to be given to the development of a regulatory framework in which the new models would operate
- There needs to be an accompanying strategy of research and evaluation of new models in terms of their clinical outcomes, service outputs, cost and clinical effectiveness and consumer experiences.
- What is the potential interface of the new models for nursing and community and /or social care? How might these different areas compliment and support mutual benefit for business and patient/client care? Tier 3 nurse consultant services for people with disabilities/ LTC? Children with complex needs?
- Need to look at the whole development of nursing in primary care from HCA or Health Trainers to consultant level practitioners, and then nurse partners and 'entrepreneurs'. The pre and post reg education will need to be reshaped and changed radically. Should there be a primary care career pathway?
- To unlock the potential of community based nurses changes in the structure and culture of PCTs will be required. This may include a review of the PEC membership and the where this has not already happened, creation of a post at Director level to provide nursing leadership.
- The PCT lead nurse also needs to influence the commissioning of services and oversee professional development and practice.
- A strategic overview of primary care services needs to be taken by PCT Commissioning teams, or to be overseen by the SHA otherwise there is a risk of further fragmentation and duplication of primary care nursing services especially with the implementation of Practice based commissioning.
- All primary care nurses contribute to improving patient and population outcomes but the explicit contribution of nursing is poorly understood and often not captured

in information systems. PCTs should work with providers to develop mechanisms and information systems that identify and track the nursing contribution to health gains and meeting health targets

5 Conclusion

Repositioning the community and primary care based nursing workforce will take energy and commitment from the nursing and other sectors. NHS organisations and professional bodies will need to support entrepreneurial behaviour amongst nurses and the setting up of alternative models of service. The evidence shows that nurses working independently within a collaborative framework will provide a different and improved model of primary care

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Annex 1 Current Position

Nursing represents a significant and varied professional group within primary care. First, there are practice nurses and nurse practitioners most of whom are employed by GPs. Second, there are district nurses, health visitors and school nurses employed in England by PCTs. This section sets out the key characteristics of each group.

- 2.1 Practice nurses** are employed by GPs and work solely with patients registered with the practice. The vast majority of practice nurses work part-time, one third work 20 hours or less a week (Audit Commission 2004). Terms and conditions vary widely between practices. As do access to training and clinical supervision. The nurse's workload is largely controlled by the flow of patients referred to them by the GP(s) and by the organisation of clinics and other services run by the practice. There is no consensus on the scope of practice nursing or the degree of specialisation and as a consequence we have seen the role of the practice nurse expand over the last 15 years.
- 2.2** Practice nurses make up a small proportion of the total nursing workforce less than 1 in 20 qualified nurses (WTE) work in general practice (13,563 in 2004). This includes a small but growing number of nurse practitioners. The number of practice employed nurses has increased by 34.5 per cent since 1997 and over the last three years the growth has been 4.5 per cent per annum (DH 2005). One in three practice nurses is over 50 (Audit Commission 2002). Some practices have reported they are finding it increasingly difficult to recruit nurses due to local competition for experienced nurses between themselves and new providers of primary care such as NHS Walk-in Centres and NHS Direct.
- 2.3** A **nurse practitioner** has been defined as a nurse who has 'undergone further training, often at graduate level, to work autonomously, making independent diagnoses and treatment decisions. In this way, they may potentially substitute for doctors' (Horrocks et al 2002). The term nurse practitioner however is used inconsistently. There is much debate about the role because of overlaps with other nursing staff in the UK. The introduction of the title nurse consultant has added to this ambiguity. At present there are no agreed national standards for the role or the skills, competencies and training required by

nurse practitioners. Since 2003, the Nursing and Midwifery Council (NMC) have recognised nurse practitioners as registered nurses who have a clinically focused Masters degree or equivalent, meet nursing council assessment criteria and competencies, and have four to five years experience at an advanced level in a specific scope of practice. Previously there was no marker. No data is held centrally on the number of nurse practitioners working in primary care.

- 2.4 Skill mix in general practice** is 1 nurse for every 2 GPs. This is very different from that in hospitals, 4 nurses to every doctor or 12 nurses to every consultant (Audit Commission 2002). The new primary care contracts (PMS and GMS) are prompting changes. For example, there are an increasing number of practices employing healthcare assistants. Anecdotal evidence would suggest that although the number is small it is growing. No data is held centrally. Some GP practices are not filling partnership vacancies and are instead appointing additional nurses. For example, a visit was conducted to one practice with 2 GP partners who are working closely with 4 experienced nurses (2 are qualified nurse practitioners) to cover a patient list of 6,900. The nurses are dealing with around 90 per cent of patients with un-differentiated diagnosis while the GPs are dealing with patients with 'complex conditions'.
- 2.5 District nurses and health visitors** collectively known as community nurses are usually attached to a GP practice(s) and work across a defined geographical area. Their caseloads vary depending on the population they serve, the staffing levels of their employer and local socio-demographic factors, among others. Most of these nurses accept 'cases' mainly from the GP but also from other nursing staff, social service and hospital staff. The nature of health visiting means that some of their work is not determined by referral alone but rather legal requirements. Rather than one-off discrete interventions, these nurses are involved in the care of patients often over extended periods of time.
- 2.6** There are many accounts of **district nurses** work evolving to meet new external demands such as increasing numbers of very old people living at home requiring complex packages of care

(Mc Intosh et al 2000, Goodman et al 2003b). This has led to changes in the structure and organisation of district nursing teams. Junior qualified nurses or social service carers have taken on some of the traditional aspects of district nurses work and the role of the district nurse has been likened to that of care co-ordinator (Goodman et al 2003a, Speed and Luker 2004). The majority of district nurses with team leader responsibilities hold a degree level post-basic qualification (Audit Commission 1999). In 1997, more than three-quarters of qualified district nurses were aged 50 years or over (Audit Commission 1999).

2.7 Changes to the structure and organisation of **health visiting** do not appear to have occurred to such an extent. Overall, most of these nurses focus on providing care to children up to the age of 5 years and their families. Studies have shown that health visitors are the least integrated members of the primary health team (McMurray and Cheater 2004). Many health visitors feel that their public health role is marginalised in the current GP-centred model of primary care. A few PCTs have used the implementation of the new GMS contract to review health visiting services but no examples of radically different patterns of service delivery have yet been found. In fact, in some instances integrated nursing teams (DNs and HVs working together) that were introduced under GP fund-holding have disappeared with the demise of fund-holding, and practices and PCTs have found themselves locked back into the traditional model of different groups of nurses working in their defined groups. Some Trusts have introduced the notion of self-managed teams whereby the staff budget is devolved down to a group of health visitors or district nurses to manage themselves. The nurses are still dependent on Trust policies for staff training, personnel issues and recruitment but are able to determine the skill mix of the team. Some district nurses and health visitors are seconded to a GP practice through a PMS contract.

2.8 Skill mix in community nursing the number of qualified nurses working in the community without a post-registration qualification in district nursing or health visiting has increased dramatically since 1997 from 13,061 to 23,232

WTE (77.9% increase). Some of these nurses are working with qualified health visitors and district nurses, others are working for new providers such as NHS Walk-in Centres and NHS Direct.

2.9 School Nurses are registered nurses some of whom have a degree level qualification as specialist community public health nurse. The workforce is relatively small. In 2004, there were 1619 nurses in school nursing.

2.10 Overall pattern of primary care nursing services currently, the composition of the various nursing groups working in the community depends on local policies, historical precedents and size and type of general practices. There are many variations, with district nurses in some areas staffing practice treatment rooms; health visitors administering childhood immunisations, counselling and cardiac rehabilitation; and practice employed nurses and phlebotomists undertaking some home visits. Historically, the distribution of practice nurses followed that of GPs so community nurses often 'filled the gaps' in under-doctored areas by staffing practice treatment rooms. Some PCTs have now started to employ 'practice nurses' to address these disparities. In 'over-doctored' areas it would appear that in some cases there has been little if any investment in community nursing services. The fact that no central government targets have been set in this area may have influenced some PCTs investment decisions. Of course, this may now change with the new targets set for community matrons and school nursing (Annex 1).

***Community Matrons** are qualified experienced community nurses who take a lead in providing personalised care and health advice for patients with complex health problems. They are supported in their work with inputs from a range of health (and social) care workers including health trainers. The level and nature of this support will depend on the locality and client groups being served.*

By 2008, there are to be 3,000 Community Matrons across England.

Annex 2

Different Contracting Mechanisms

Contracting Route	Provider
General Medical Services (GMS)	Practices with at least 1 GP provider (partnerships or a certain type of limited company).
Personal Medical Care Services (PMS)	Any member of the NHS Family (GP partnerships, Trusts, nurses and other clinicians).
Alternative Provider Medical Services (APMS)	Commercial Providers, Not for profit organisations, Voluntary sector, Co-operatives and others.
Specialist Personal	Medical Services (SPMS) Service provided by a member of the NHS family to an unregistered population or a population with specific needs. This does not need to include the provision of essential services.
PCT Medical Services (PCTMS)	Service is directly provided by the PCT.

Different Organisational Forms

Professional Partnerships

General practice has traditionally used the organisational form of professional partnership whereby partners have been involved in many (if not all) aspects of the business and decisions are made by partners reaching a consensus. The partnership structure in other professional organisations such as law and accounting has been seen as increasingly problematic and moves have been made over the last 15 years to re-structure such organisations into managed professional businesses (Cooper et al 1996, Brock et al 1999). In these organisations, there are a smaller number of partners, a greater number of employees and staff are appointed specifically to manage and market the business. In general practice, there is increasing interest to look at alternative legal forms and some GP partnerships have already established private limited companies to run and oversee any enhanced services they are providing.

Limited Liability Partnerships

A new form of partnership was introduced in 2001 called Limited Liability Partnership (LLP). Few GP practices are yet using this legal form. To date it has mainly been used in accountancy and legal firms to shield partners from the unlimited liability of normal professional partnerships. Formally, a LLP is a written

agreement similar to a partnership agreement used in traditional professional partnerships. The difference is that this is registered a Companies House. There are no statutory requirements for detailed articles and accounts to be registered at Company House. For tax purposes, LLPs retain the advantages of professional partnerships but with the added benefit of limited liability rather than the joint unlimited liability of traditional partnership. Since, organisations can also be members of an LLP, a patient organisation or an independent nursing team could be included as a member of the LLP.

Limited Companies

Limited Companies and Companies Limited by Guarantee are answerable to members rather than shareholders and must be registered at Companies House. Decisions are made by voting and Directors are appointed to run the business. Shareholders (or members) set the framework for Directors to work within.

Industrial and Provident Societies

There are two main types of Industrial and Provident Societies (IPS): a mutual or co-operative is owned by members for its members and a mutual that provides services for people other than its members for the benefit of the community. In both cases, members own the organisation with each usually owning one share which cannot be traded or transferred, and which provides no rights to interest, dividend or bonus. A disadvantage of IPS is the amount of additional regulation. For example, an organisation needs to prove to the regulator (FSA) why it needs to be an IPS rather than another type of company.

Community Interest Companies (CIC)

This a new type of legal organisation introduced in 2002 to incorporate Public Interest Companies. An organisation wishing to be a CIC can choose one of three company forms: private company limited by shares, limited by guarantee or public limited company. CICs are restricted from distributing profits and assets to their members. This is known as an 'asset lock' and is a safeguard from possible demutualisation and loss of assets. The Government 'does not intend that CICs should deliver essential public services in core sectors such as hospitals or schools' so if used within primary care services it would need to be deemed 'additional or enhanced' rather than core.

3.3 Social enterprise Social enterprise organisations use business skills to achieve social aims such as bringing benefits to communities and society rather than being driven by the need to maximise profit for shareholders and owners. Until now there has been limited transfer of these capacities into the public sector. Yet, the literature shows that such organisations often demonstrate innovative new practices to service delivery, are self-reliant, focused on outcomes and have a strengthened accountability to their constituents. Such characteristics fit in well with the government's aims and objectives of creating a Patient-led NHS. The value set of social enterprise organisations may well suit the needs of some local communities and the values held by some nurses.

Annex 3

Potential Model for Primary Care Services in England

Below is a brief description of a model for primary care services currently being discussed in the Department of Health.

Tier 1 open access to routine single episodes of care, building on the walk-in centre model but extended to all aspects of primary care, with appointments also available which patients can book via the telephone or internet. Patients would not have to be registered with these services to access them.

Tier 2 access to a general practitioner or a practice for ongoing care. For example, long term or palliative care conditions such conditions may require ongoing co-ordination by a GP and/or nurse and/or referral to hospital. These will be provided by a practice with which the patient is registered. There will need to be sufficient capacity to ensure a choice of practices. Whilst people wish to have access to the most appropriate professional at a time and place most convenient to them, the importance of continuity of care is ensured through registration with at least one practice.

Tier 3 Access to specialists in primary care, normally referred via Tier 2. This will include GPs and nurses with a special interest, and services previously provided in secondary care such as dialysis, chemotherapy and, gynaecology. Diagnostic facilities may also be available.

Annex 1

SKOLL CENTRE for SOCIAL ENTREPRENEURSHIP, SAID Business School, University of Oxford.

Developmental programme for nurse entrepreneurs in primary health care

Strategic aim

To support government policy to increase patient choice through a diversity of providers, using nurses as an untapped resource.

Programme objectives and outcomes

This programme recognises the emergent nature of this work and centres on four main objectives:

- To develop participants' entrepreneurial capabilities. This is principally about changing mindsets, strengthening entrepreneurial behaviour and acculturating nurses to new operational parameters.
- To develop an understanding of social enterprise models and enable participants to prepare a strategic plan to develop their own – recognising it may be appropriate for some to work within existing structures.
- To provide an introduction to practical aspects of managing social enterprises.
- To develop and promote managerial resources to assist participants and stimulate the wider uptake of new business models in primary care.

The outcomes will be:

- Nurse led independent services that maximise the freedom created by the new contracting mechanisms.
- A more level playing field between nurses, AHPs and GPs, dentists and pharmacists.
- Increased knowledge and understanding of how social enterprises work in primary care.
- A cohort of entrepreneurial primary care nurses and AHPs setting up new social enterprises.
- The stimulation of new business models in primary care with strong NHS and nursing values.

Programme parameters

This programme is intended for up to 15 nurses and AHPs working in primary care settings. The programme is built around four study sessions:

1 Becoming a social entrepreneur

This will comprise familiarisation with a wide variety of social entrepreneurship models both in objectives, and managerial styles (charismatic individuals, entrepreneurial teams, partnerships and democratic governance models). It will incorporate an introduction to analysing need and identifying resources. It will also enable participants to reflect on their own preferences and model other social entrepreneurs' behaviour. A variety of learning methodologies will be used

2 Designing enterprising solutions

This session will use higher levels of taught input by providing a detailed overview of social enterprise models, and include discussions about public sector interfaces. Introduce key principles on strategy, finance, performance and accountability. Case studies and external speakers will be more context specific for example, the Bromley-by-Bow healthy living centre.

3 Implementing social enterprise models

This session will open with detailed presentations and development of participants' strategic plans. Teaching will focus on key aspects of marketing, operations and managing people, and provide an overview of the funding landscape. Case studies/project visits/external speakers will incorporate sharing of start-up experiences and help provide bench marking.

4 Gathering momentum

This session will come back to the leadership and behavioural aspects of social entrepreneurship. We will explore the barriers to success and successful strategies for overcoming them. Taught input will look at mobilising networks and stakeholder management. Participants will review their personal development needs. Case studies will incorporate discussions about values, failure and growth. Taught input will close with sign-posting to practical resources, including constitutional and legal advice, help with becoming an employer and options for personal support. The programme will close with practice pitches to funder panels, which enable participants to bring all their planning together, make a strong case and gain confidence with feedback from a range of potential investors.

Logistics and dissemination

Study sessions will begin in September 2005 and conclude in July 2006. They will be three days long each and held at the Saïd Business School in Oxford. An interim report will be supplied on completion of the second study session, and a final report at the programme end. Meetings of the reference group will be convened at these two points and once more during the initial development period. The programme provides an opportunity to support a wider shift in nursing practice and dissemination through a variety of routes is planned at the end of the programme including the 2006 Skoll World Forum on Social Entrepreneurship.

Appendix 3

Directory of Universities in Greater London Area offering Nursing and Health Care Courses and Programmes

Buckinghamshire Chilterns University College

Faculty of Health Studies
Chalfont Campus
Gorelands Lane
Chalfont St. Giles
Bucks
HP8 4AD

Tel: 01494 603171

Website: www.bcuc.ac.uk

Croydon College of Further and Higher Education

Barclay Road
Croydon
Surrey
CR9 1DX

Tel: 020 8686 5700 ext 3648

Website: www.croydon.ac.uk

Brunel University

School of Health Sciences and Social Care
Uxbridge
Middlesex
UB8 3PH

Tel: 01895 274000

Website: www.brunel.ac.uk

City University (St. Bartholomew)

School of Nursing and Midwifery
20 Bartholomew Close
London
EC1A 7QN

Tel: 0207 040 5700

Tel: 0207 040 5720 (Admissions Office)

Fax: 0207 505 5717

E-mail: healthprofessionals@city.ac.uk

Website: www.city.ac.uk/barts

Kings College, University of London

King's College London
Florence Nightingale School of Nursing & Midwifery
James Clerk Maxwell Building
57 Waterloo Road
London SE1 8WA

Tel: 020 7848 4698

Website: www.kcl.ac.uk

Kingston University and St. Georges Hospital Medical School, London

Faculty of Healthcare Sciences
Admissions Office
Kingston Hill
Kingston-upon-Thames
KT2 7LB

Other Centres: Croydon, Epsom & Richmond

Tel: 0208 547 8736

Fax: 0208 547 8766

Website: www.kingston.ac.uk

London Metropolitan University

31 Jewry Street
London
EC3N 2EY

Tel: 020 7753 3355 (Undergraduate Admissions)

Tel: 020 7753 3333 (Postgraduate Admissions)

Email: admissions@londonmet.ac.uk

Website: www.londonmet.ac.uk

Middlesex University (London)

Admissions Unit
Health and Archway Campuses
St. Mary's Wing
Whittington Hospital
Highgate Hill
London
N19 5NF

Other Centres: Enfield, Royal Free

Tel: 020 8411 5161

Website: www.mdx.ac.uk

London South Bank University

Faculty of Health & Social Sciences
103 Borough Road
London
SE1 0AA

Other Centres: Harold Wood and Leytonstone

Tel: 0207 815 7815

Fax: 0207 815 8273

Email: enquiry@lsbu.ac.uk

Website: www.lsbu.ac.uk

Thames Valley University

Faculty of Health and Human Sciences
Westel House
32-38 Uxbridge Road
Ealing
London
W5 2BS

Tel: 0800 0364036

Email: healthenq@tvu.ac.uk

Website: www.tvu.ac.uk

Other Centres: Slough, Reading

University of Greenwich

School of Health
Avery Hill Campus
Bexley Road
London
SE9 2PQ

Other Centres: Bexley, Bromley, Canterbury, Dartford, Maidstone, Medway & Sidcup

Tel: 020 8331 8590 (Course Enquiries)

Tel: 020 8331 8044 (Admissions)

Website: www.gre.ac.uk

The Open University

School of Health and Social Welfare
Walton House
Milton Keynes
MK7 6AA

Tel: 01908 653 743

Website: www.open.ac.uk