

Developing key roles for nurses and midwives

a guide for managers

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The aim of this publication is to:

- Help managers implement key roles for nurses and midwives
- Share case studies of good practice
- Provide checklists for developing key roles
- Support managers and their colleagues as they develop key roles

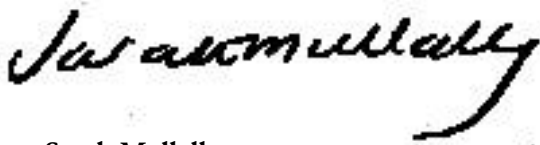
Foreword by Sarah Mullally, Chief Nursing Officer

Across the country nurses and midwives are working in different ways, developing their roles to improve the patient's experience of care. Drawing together a range of case studies of good practice, useful contacts and resources, this guide aims to help managers by providing ideas and practical ways of meeting service objectives.

The guide identifies some of the core principles that underpin the implementation of key roles along with some practical tips on how to best manage change to achieve the desired results. It also highlights some of the lessons to be learnt from those that pioneered this work in different clinical areas and across a range of different health care settings.

The importance of effective leadership in the successful management of change cannot be underestimated. The guide acknowledges the efforts of individuals, encouraging managers to identify and share good practice in shaping new roles and finding new solutions to complex challenges wherever they work in the NHS.

I am delighted to introduce this guide for NHS managers to support nurses and midwives to implement the 10 key roles set out in *The NHS Plan*.



Sarah Mullally
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London



Introduction

Staff are the key to reform and to achieving the modernisation agenda in the NHS. Nurses and midwives make up the largest proportion of the NHS workforce. It is therefore well worth managers' while to invest in the development of their skills to help meet service objectives. As *The NHS Plan*¹ says 'it is about working smarter to make the maximum use of the talents of all the NHS workforce.' As a result, nurses and midwives are being empowered to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs. The Chief Nursing Officer identified 10 key roles for nurses which form the core of the development of their contribution to the new NHS.

Two years ago *The NHS Plan* charged managers with the task of making change happen. They are in the driving seat of the biggest change in the NHS since its inception over 50 years ago. *The NHS Plan* and *Making a Difference*², the Government's strategy for nursing and midwifery, highlighted the need to introduce new roles and new ways of working for nurses and midwives to help improve services and drive up the quality of patient treatment and care.

The old demarcations that have held back staff and slowed down care are being broken down and nurses and midwives are taking on a wider range of clinical tasks. Nurses' and midwives' roles have changed dramatically and as frontline staff they have a fundamental part to play in developing the new NHS. They are often the group of staff who are closest to patients and therefore are crucial in achieving a patient-centred NHS. The successful future of the NHS depends on a workforce able to work in different ways. Managers can make best use of nurses' and midwives' skills by reviewing their current roles and looking at innovative ways to develop key roles.

This booklet

The aim of this booklet is to provide NHS managers with practical examples of nurses and midwives who are working smarter to provide the services that patients want and which help meet NHS objectives. It also describes how these new ways of working were introduced, and the legal and professional frameworks that make them possible.

Innovation is already happening and the practitioners who are doing it are the best source of information and inspiration. The case studies in this booklet show how local innovations are responding to national priorities and will provide inspiration and practical ideas.

These key roles support new health strategies and government policies, and enable nurses to realise their full potential to work as part of the wider health

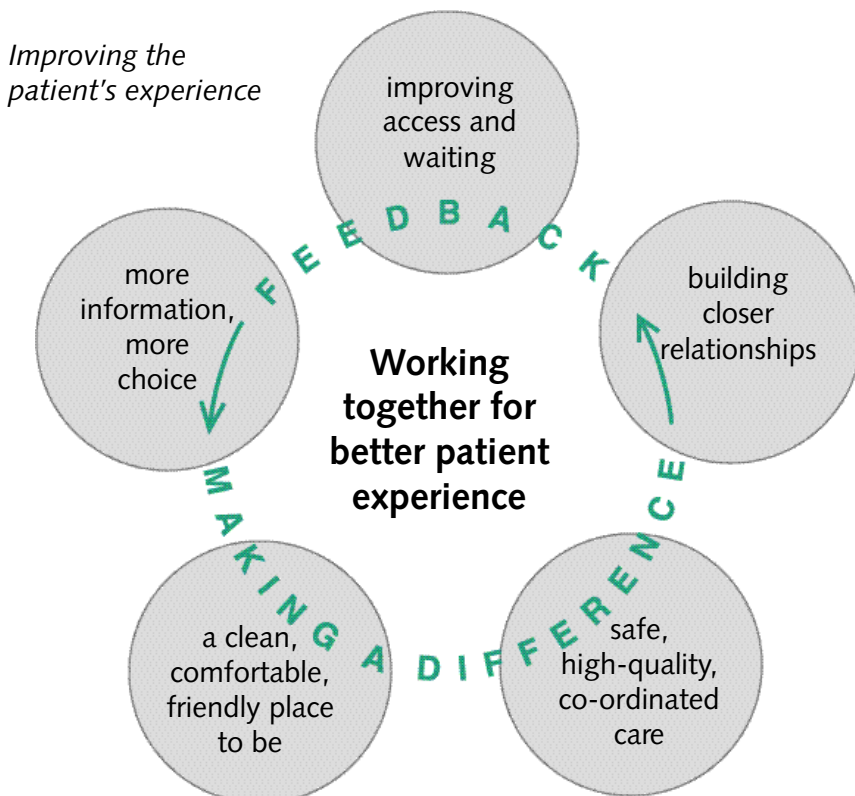
care team, complementing and working collaboratively with others. They can play a key part in breaking down barriers between professionals and in providing a patient-focused service.

This booklet includes:

- case studies of the key roles in action, including lessons learned, helpful pointers, and outcomes or service improvements resulting from the role
- a checklist that will be helpful to managers when introducing the role
- a description of the legal and professional boundaries affecting the roles
- examples from the evidence base on role substitution and role development by nurses
- a list of relevant organisations, websites, publications and contact details for the case study sites
- information about protocols, training materials and other resources that are available from case study sites.

Improving the patient's experience

Improving the patient's experience is a major initiative intended to help design the NHS around patients, where staff are equipped to deliver high quality services that are accessible, responsive and appropriate to meet the needs of patients as individuals³. The diagram below shows how improving the patient's experience is at the heart of the drive to improve services and is at the centre of *The NHS Plan*.



CNO's 10 key roles for nurses

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

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Reality check: the case studies

Managers have a wide range of key service objectives to deliver. We have focused on four main areas and shown how nurses and midwives are developing roles and ways of working that will contribute to achieving these.

Speeding up access

The public's top concern about the NHS is waiting for treatment. *The NHS Plan* focuses on patients' needs to have quicker access to a whole range of services including inpatient surgery, to their own GP, to a booking system for appointments and treatment, together with an end to long trolley waits in A&E. In primary care, intermediate care and hospital care there are clear objectives to reduce waiting and access times. By the end of 2005 waiting times at all stages in a patient's care will have fallen.

Improving treatment and care

Throughout the NHS patients and staff are working to improve treatment for patients: to deliver quality treatment more quickly, in a place that suits the patient's needs and life style, by the most appropriate staff. By 2004 NHS staff will be working under agreed protocols identifying how common conditions should be handled and which staff can best handle them.

Patient Group Directions enable nurses and other registered professionals to supply medicines to patients. By 2004 the majority of nurses should be able to prescribe or supply medicines to patients.

Responding to patients' needs

A major thrust in *The NHS Plan* is to change services so they improve patients' overall experience of the health services. This can be influenced by things such as seeing a health professional who can deal with many of their problems: a 'one-stop shop'; a professional who can view the person in an holistic way; less duplication of services; and greater continuity of care. Nurses and midwives are developing their role in public health and family well-being. They are working with local doctors, other nurses and midwives to develop maternity and child health services and Sure Start projects.

Making best use of nurses' and midwives' skills

All improvements in the NHS hinge on recruiting and retaining staff with the right training, skills and values. The vision of the NHS in *The NHS Plan* is of a service where careers are developed, not stagnant, and of a renewed public health ethos. Radical changes are needed in the way staff work to

reduce waiting times and deliver modern, patient-centred services. It is about working smarter to make maximum use of the talents of all NHS staff.

Case studies

These examples of care cover many areas but they are used here to emphasise particular aspects of the four main areas we have identified. Each of the case study originators is happy to share their experiences and they can be contacted at the details given in the Factfile in Section 4. Many also have examples of protocols and job descriptions that they would be pleased to share with others considering implementing similar roles.

1. Sheila Adam:

Ordering diagnostic investigations

The Critical Care Outreach team at the Middlesex Hospital have been trained in advanced clinical assessment skills so they can request X-rays and, in emergency situations, interpret X-rays. The team assess patients referred by the ward staff to determine the likely cause of acute deterioration using algorithms to identify the need for an investigation. There is always someone on hand to turn to for advice. Ward nurses now have assistance to respond speedily to patients' acute problems – this saves time and means patients get a necessary investigation at the time they need it and more quickly than previously.

A one-week course, consisting of at least six hours of practice interpreting X-rays, was designed by radiologists. Nurses have an annual review of their skills.

Nurses bring an holistic approach to the care of patients – they can co-ordinate the patient's needs and the approach frees up medical staff. This approach means patients get the care they need when they need it; ward staff get the support they need, and nurses' credibility and confidence is enhanced as their clinical skills are used appropriately.

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2. Helen Dunshea:

Making and receiving referrals direct

A parent advisory service (PAS) is offered by a team made up of a school health adviser, two health visitors and a secretary who receive referrals from any health care worker relating to children up to 16 years of age with mental health difficulties. The Child and Adolescent Mental Health Services (CAMHS) were being swamped with referrals and this service was set up so that children could be seen without delay.

Because children are seen more quickly and referrals to CAMHS are now more focussed, it means that the CAMHS service is used more efficiently. The CAMHS team provided training for the PAS team members.

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The service means there is wider access to mental health services in primary care. The audit shows that families value accessibility of the service, the fact that the team visit at home and that there is liaison between school and home. School health advisors' skills are being used creatively and they are working in different ways.

'It's not rocket science'

3. Shelagh Cartmell:

Making and receiving referrals direct

General practitioners can make sure their patients can get into hospital quickly and in a timely way through the nurse-led medical assessment unit in Durham. The nurse-led service is three years old. Admissions have been centralised through one person who co-ordinates GPs' access to medical beds. Patients not only get into hospital more quickly but are referred to the most appropriate ward. Together the GP and nurse make the decision about when the patient will be admitted, so that patients can stay at home until a bed is available, and trolley waits are reduced.

A protocol has been developed in collaboration between nurses, GPs and hospital doctors. One person is dedicated to organising admissions and is able to meet patients' needs in the most efficient way, organise any relevant tests and negotiate better planning of patient pathways.

'Not difficult to implement'

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4. Pam Leonard:

Admitting and discharging patients

More efficient bed occupancy is one of many targets of the Practice Development Unit at Wirral Hospital. Patients were waiting for the house officer to come round to be discharged. As this was frequently after 9am it delayed discharge and subsequent re-allocation of the bed. Now senior primary nurses and the ward manager will be responsible for discharging patients. They will co-ordinate social and occupational therapy requirements, clinical requirements, and the discharge letter with any follow up appointment details. The consultant will have previously set the parameters for discharge and the nurses ensure that all the criteria have been met. They are putting a nurse discharge screen on the computer.

The process speeds things up for the patient and provides a more coherent package of information to help continuity of care. Beds will be available earlier in the day to ensure optimum bed use.

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5. Shelagh Cartmell:

Admitting and discharging patients

The majority of patients with deep vein thrombosis no longer have to stay in hospital to receive care. In Durham, nurse practitioners see DVT patients referred in the out-patient clinic. They check patients, take a history, carry out tests and flag up the results to the consultant. This approach cuts down on bed stays and provides better care for patients.

Nurses undertook a three-month clinical skills course to develop their expertise and continue to have one study day a month with the consultant team and regular clinical supervision. They have developed protocols for dealing with DVTs, a 'map' of the patient journey, a risk score, investigations and day-to-day out patient management. They are currently exploring nurse prescribing possibilities.

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6. Helen Watson:

Managing patient caseload

The neonatal care services are provided entirely by specialised advanced neonatal nurse practitioners (ANNP) at Ashington Hospital, Northumberland. Northumberland has a well-developed community-based paediatric service but has never had any inpatient paediatric services. A team of eight experienced and specially trained nurses have round the clock responsibility for the care of all babies in the maternity unit with immediate access to a consultant neonatal paediatrician in Newcastle for support and advice. Nurses completed the ANNP course and have gone on to further develop their skills.

Staff time is used economically because there is no artificial segregation of nursing and medical duties. Parents find it easier to build up a rapport with senior nursing staff whose expertise they quickly come to trust. An evaluation has shown that suitably trained nurses can, with access to consultant advice, provide neonatal care to the same standard as recently qualified doctors. Parents work with a permanent team member with a store of experience who provides more continuity than staff rostered to this task for just a few months. Investing in staff who will stay in post is clearly advantageous.

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7. Valerie Goode:

Running clinics

Valerie Goode, nurse clinician at the Christie Hospital, identified that patients with lymphoma needed more nursing input together with consistency and continuity in their care. She attends five to six outpatients clinics a week, seeing patients in the same way as doctors. In 1995 when she set up the role, there were no other lymphoma specialist nurses in the country so the support of the nurse director and consultants was important.

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Staff believe that the standard of care for out-patients has improved and a comprehensive audit of the nurse clinicians' roles is planned. Valerie aims to spend time with patients and give them consistency of care and approach. She can carry out a range of services for patients – for example, order investigations, write to their GPs, refer and perform bone marrow biopsies. She can address patients' concerns, manage their physical problems, act as a patient advocate and make independent clinical decisions.

'Patients get the care they need where they need it'

8. Dorothy Miller:

Prescribing medicines and treatments

Elderly patients at the Garden Lane Medical Centre, Chester, enjoy continuity of care, longer appointments and prescribing from the practice nurse Dorothy Miller. Looking after a population of 700 patients, Dorothy visits the frail elderly at home, and looks after those who have had strokes, Parkinson's Disease and have mental health problems. She organises medication in blister packs, records any changes to medication and co-ordinates the results of hospital visits, tests and discharge medication, implementing the necessary changes.

Dorothy prescribes from the Nurse Prescribers' Extended Formulary. She generates a hand-written prescription and then all records go onto the computer. The aim is to generate a nurse computer prescription.

To support this service, the practice has developed Patient Group Directions for eye care, bowel care, urinary tract infections and dressings.

She also visits elderly patients in nursing homes and checks they have been prescribed drugs and any appliances such as catheters or dressings, appropriately.

As a result of this development elderly patients have a central point of contact, and there is less duplication of effort as all queries about elderly patients are directed through one person.

'Making a real difference to people's health: following care through from beginning to end'

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9. Angela Bates:

Prescribing medicines and treatments

Homeless and vulnerable people were asked about their health care requirements when the Cheshire West PCT were developing a primary service to respond to their needs. Angela Bates, a nurse clinician, works with homeless and vulnerable people. She carries out health needs assessments, enables people to access services such as mental health more quickly than before, and prescribes medication from the Nurse Prescribers' Extended Formulary as appropriate. She offers people a consultation, assessment, examination and treatment or referral that is appropriate to their needs.

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As a result there is less duplication of services, homeless people feel less stigmatised, they have greater continuity of care and speedier access to appropriate services. The service may prevent them going to A&E and possibly needing hospital admission. It also means they have one point of access rather than going from one GP to another in the area.

Angela Bates works closely with key voluntary organisations, probation services, the housing department, the police, local GPs and A&E services. Her role fills an identified gap. It makes a real difference to people's health and follows their care through from beginning to end.

Protocols and Patient Group Directions have been developed together with a hand held record. The PCT has undertaken to continue funding for the service and GPs in the area are supportive.

'Important to meet needs of population you're serving rather than fitting resources to them. If you don't meet their needs, they won't use it! [the service]'

10. Debbie Hughes:

Carrying out resuscitation procedures

A team of highly-trained nurses triage patients with ischaemic chest pain and have drastically reduced the time delay between the patient's arrival in hospital and the time treatment starts.

The nurses work across directorates, including A&E, and see emergency admission patients who have not been seen by doctors. They co-ordinate ordering of investigations, manage subsequent treatment and ensure patients receive appropriate medication.

The stimulus for the development came from research into the therapeutic benefit to patients of reducing the time between onset of chest pain and starting treatment. From arrival in hospital, the delay to treatment has been reduced to 21 minutes [30 minutes is the target for national response for patients with acute myocardial infarction – April 2002]. Working in partnership with cardiologists, nurses were given training in history taking and reading ECGs. Protocols were developed and legal advice taken to ensure risk management considerations were taken into account.

Nurses are using their skills effectively, and have had an opportunity to shape and develop the workforce and to influence national policies and protocols. Patients are receiving high quality, timely treatment. Nurses are now involved in teaching new doctors and working with them. The unit's work has been recognised with the award of Beacon status.

'Opportunity to work in ways never thought possible'.

'About empowering the staff we have, not necessarily about employing more staff'.

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11. Roy Pryer:

Carrying out resuscitation procedures

In Brighton, nurses have extended their skills as part of the resuscitation team. Resuscitation training, from newborn to adult, is offered across the trust to all nurses and medical staff. The team are responsible for advising on equipment, auditing outcomes, safety checks and attending cardiac arrests. Nurses have developed advanced roles in inserting laryngeal mask airways, defibrillating and administering Epinephrene before the arrival of the medical team. Mannequins are used for training which gives nurses ample opportunity to practice. Nurses diagnose cardiac arrest, read rhythms and defibrillate independently. A study of the relationship between nurse-led defibrillation and survival showed better survival rates after one year than without nurse intervention. The advanced skills learned by nurses play a major role in improving patient care with fewer complications and less likelihood of neurological complications.

Nurses have developed confidence and morale and have greater career opportunities as a result of the development. The next stage is to identify key trainers on the wards who have a direct link with the training department.

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12. Susan Osborne:

Performing minor surgery

Patients at St Mary's, London benefit from the skills of two nurse practitioners who have advanced clinical roles. One nurse practitioner carries out minor surgery: GPs refer direct to her and she runs a 'one stop' evening 'see and treat' clinic to meet the needs of patients out of hours. The other, a nurse consultant, performs diagnostic coloproctology in her own clinic.

This development was stimulated by the need to reduce junior hospital doctors' hours and tackle waiting lists, and the desire to develop a more responsive service. Both nurses provide an holistic approach and have set up patient focus groups to obtain feedback.

Both nurses had additional training to perform minor surgery – the skills laboratory was invaluable – and were supported by the Professor of Surgery, Ara Darzi.

Patients benefit from a 'one stop clinic' that is responsive to their needs – they do not get sent to a number of different departments and the evening clinic hours suit those who work. GPs receive feedback about their patients' progress and there is less duplication of medical involvement. Both nurse practitioners are making better use of their experience and skills and are pushing the boundaries of what they can achieve. There will be six nurse consultants shortly who will act as catalysts for change and promote what they are doing internally.

The Trust is about to start an 18-month pilot that will assist further with the reduction of junior doctors hours and develop new ways of working for nurses and Allied Health Professionals. The role of the peri-operative

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surgical practitioner (PSP) will be developed using a skills laboratory approach to train twelve nurses and AHPs to undertake aspects of Senior House Officer roles. The training will include patient assessment and clerking and various invasive procedures such as insertion of central venous pressure lines and taking blood gases.

It is envisaged that on completion of the training the PSPs will manage their own patient caseload and work as part of the SHO rotation with a surgical consultant's firm.

13. Andrew Jackson:

Performing minor surgery and outpatient procedures

Patients in Rotherham benefit by being referred earlier to the nurse consultant for intravenous therapy and care. Andrew Jackson, nurse consultant in IV therapy and care at Rotherham General Hospitals NHS Trust manages a team of nurses who work across specialties, caring for patients' vascular access needs including the insertion of Peripherally Inserted Central Catheters (PICCs).

The nursing team assess patients' needs, developing a plan of care that ensures patients have appropriate access devices inserted, staff are appropriately trained to care for these patients and care is delivered in the appropriate environment including the outpatient/community setting. These patients are referred to the team by surgeons, orthopaedic doctors, chest physicians and others.

Patients benefit from the vascular access service because they have access appropriate for their therapy. Consequently they rarely miss doses of medication and get reliable IV access. Patients can be referred direct from outpatients thus saving bed stays for some patients.

Andrew and his team work across directorates; they have clinical credibility and people often seek advice from them. The development is the result of partnership working between Andrew and his manager. Clinical governance issues are crucial and the approach reflects these.

Like other nurse consultants, Andrew's role combines clinical responsibilities and education, research and leadership. His role gives him the freedom to push things on and also to bring issues together in the interests of patients and the trust.

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14. Ann Ballarini:

Triaging patients using latest IT

The NHS Direct Clinical Assessment System (CAS) is being used in primary care to triage patients and then bring them into the nurse-led minor illness clinic. Doncaster Central PCT set out to look at what could be done by health care professionals other than the general practitioner. The idea was to triage patients so those who needed to see the GP quickly did so and others

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were directed to other health care professionals for treatment.

Their aim was to get the right patient to the right person in the right time frame. Ten of the 11 practices wanted to use a nurse triage system. Two groups were formed, one group undertook the CAS-based computerised triage system training and the second group did this together with minor illness training.

They designed their own minor illness training run by a local GP. It covered 17 minor illnesses and participants had to have their competencies signed off. Health professionals who used the CAS triage system together with minor illness training found the combination was rewarding as they could see the outcomes of the triage process.

From a clinical governance perspective, the CAS system and the tried and tested algorithms used, have been successful. There are some changes needed to the system to avoid duplication because in a primary care setting each patient already has a medical record.

15. David MacPhee:

Triaging patients using latest IT

The accident and emergency service at Northumbria Healthcare NHS Trust benefits from the use of a triage system based on a decision support software used by trained nurses. Nurse consultant, David MacPhee, had a key role in the development of a system which means that patients arriving at A&E with a minor problem are now seen by a nurse who manages their problem and often discharges patients home. Patients with more complex problems are able to see a doctor more quickly than before. As a result patient satisfaction has been increased and the pressure on the A&E department has been eased.

The department uses the NHS Direct decision-making software and has plans to develop it to link with the ambulance service. There is now much more focus on appropriate care for the patient. Nurses' skills and ability to think through problems are much better used than before. As nurse consultant, David MacPhee feels that for the first time in his career he is able to bring together his skill in clinical work, research and education.

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16. Sue Foyle:

Taking a lead in organisation of local services

Midwife consultant Sue Foyle has taken a lead in developing maternity services to respond to the needs of teenage mothers. She has linked policy to clinical practice so that it is grounded in reality. With her leadership around 20 senior nurses and midwives have been involved in writing the nursing and midwifery strategy for the trust.

Having identified a high rate of teenage pregnancy and knowing that younger women have a poorer outcome for child and maternal health, Sue has initiated strategic ways of working with teenage mothers. She works with other agencies, local groups and education colleagues and has developed a public health approach to teenage pregnancy. Sue originally had a case load

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of 30 young women; now she takes referrals from her midwife colleagues working with young women.

There was a gap in the service that has now been filled – no one was co-ordinating care for this client group and now vulnerable young women are fast tracked to the care they need, for example to a drugs worker. A life skills course has been established – young women use laptops, create a ‘baby book’ and learn transferable life skills.

Sue has gained confidence and is able to operate autonomously. Importantly, she has a position of authority but does not have a line management responsibility which leaves her free to be creative.

‘Opportunities to work in ways never thought possible’

17. Rob Crouch:

Taking a lead in the organisation of local services

As nurse consultant in A&E, Rob Crouch focuses on thinking strategically and differently for the medium and long term. He is part of the internal leadership team in the department. Working with local stakeholders, he is exploring innovative models of collaboration to see how the A&E service can be developed to meet patients’ needs.

A key feature of the A&E service at Southampton is the Minor Injury Nurses Treatment Service (MINTS). Nurses have developed as autonomous practitioners at three levels. They can now take patients further on their journey by requesting investigations, taking histories and, as a consequence, reducing waiting times in A&E.

To support the development, Rob Crouch completed a physical assessment and history taking course at Southampton University. In-house multidisciplinary courses have been developed around A&E; radiologists and pharmacists have provided training.

As a result, nurses now use a systematic approach to assessment and care, patients get better care and those with minor injuries are seen far more quickly than before. Nurse feel liberated and that their role is recognised. While there was an initial investment in training, there is a long-term gain in the quality of the A&E service and importantly, nursing staff stay in the service. The investment is in staff who are the mainstay of the service rather than in junior doctors who are going to move on.

Rob Crouch’s own responsibilities include clinical and academic involvement. The clinical care he plans and provides is underpinned by research and development, audit and teaching expertise.

‘Challenging and changing long-held beliefs of what nurses are doing’

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3

Implementing key roles: lessons from the grassroots

There is much to learn from the experience of those who have started to develop key roles. This section focuses on the lessons from around the country about what has worked in developing these roles.

The practitioners' experience

What they said about

Getting started

It is essential to plan for any change: *'think carefully about why you need it', 'focus on clear things', 'have a vision'*. Managers need to *'prepare the field first then select the right person, provide proper education and support', 'make the circle as complete as possible before implementing'*, and to *'have a process map of what's going to happen'*. There are dangers in *'trying to do too much': 'have limits on what you can do', and 'don't be all things to all people'* were warning notes for taking on too much. It is useful to see another scheme in practice before launching your own. It is also useful to have someone *'dedicated to seeing it through'*.

Top tips for managers

- Be clear about your aims and what you want to do
- Define your objectives in terms of patient care
- Look at areas where you can change working practice
- Identify benefits for the organisation, for patient care and cost implications
- Go and see other centres; see how they do it
- Start small
- Don't think you can do it all at once
- Put together protocols and outline service to be provided
- Don't reinvent the wheel

The practitioners' experience

What they said about

Supporting staff

Support is essential from a number of perspectives: *'seek as much support as possible'*, *'find your champions'* and *'win hearts and minds'* is a clear message. When working with medical colleagues, it is necessary to have their support. As one put it *'if you don't get support you can be unhappy'*. You need to identify key groups to agree to role expansion or change.

Networks with key stakeholders, interagency partnerships and good partnerships in general were all seen as essential.

Clinical supervision is essential: *'You can't get too much support'*.

Training needs must be thought about before starting the innovation: *'training is crucial'*.

No one should underestimate the time involved in making a change to roles. It is not a *'quick fix: it takes 6 – 9 months to get up to speed and change practice'*, *'you have to check yourself on changing the world in 2 weeks. Set realistic goals and see them through'*. One said it was advisable to *'start small and then to gain confidence'*.

The impact of change cannot be underestimated. You need to recognise that some people will feel threatened by change: *'having a model of change is a double edged sword. It's not a quick process when you are breaking new ground, do it a bit at a time'*, you *'need to find a way round or under any wall'*.

What they said about

Ensuring ownership

Nurses and midwives must be empowered to be able to say 'no': *'need the confidence to say 'no' when your level of expertise is going to be exceeded'*.

Top tips for managers

- Don't underestimate the amount of time needed for training
- Don't cut corners: staff must be properly prepared in terms of education
- Accept that key roles need support and development opportunities
- Understand stresses on staff
- Establish a good system of clinical supervision
- Make sure the change process is understood and supported
- Make sure there are opportunities for all staff to develop professionally
- Remember ... staff are key catalysts in the change process

- Task someone to see the project through
- Hand the reins over so practitioners can develop it themselves
- Must be grass roots up not top down
- Empower staff to say 'no' when necessary
- Increasing job satisfaction means experienced staff are more likely to stay

The practitioners' experience

What they said about

Communication

Communication is essential to overcome any preconceptions. One urged *'don't let consultants see it as taking away clinical decision making'*. Others pointed to the need to raise awareness about the initiative before it happened.

In one case local public awareness was important where changes to a primary care service would have a direct impact on the patient's route to care, *'[we] need the public to understand skills of nurses'*. It is also necessary to *'keep the service high profile'* and presentations were made to GPs and nurse about the development. It is necessary to promote what they do to *'make them feel good about themselves'*.

What they said about

Structure and funding

Adequate funding is necessary and *'funding needs to be clear from the start'*. Another said *'be creative: look at the resources available at the time'*.

What they said about

Audit and evaluation

Audit needs to be built into the system from the beginning. You can then make sure that the data will be easy to collect and to extract.

Top tips for managers

- Meet regularly: don't let staff be isolated
- Communicate with colleagues so they know what you're doing
- Get colleagues on board and supportive
- Publicise service widely
- Don't be rigid: you need to be flexible
- Keep a sense of humour
- Make sure everyone knows about the ways these key roles have benefits for patient care

- Make sure there is adequate clerical support
- Identify mainstream funding

- Audit against credible standards: patients' and colleagues' perspectives are also important
- Be honest about what does and doesn't work
- Persevere: don't give up!

4

Factfile

4.1 Legal and professional indemnity

Legal standards

There are two legal standards that apply to the expansion of nurses' roles. One is a constitutional standard ('the rule of law'), that requires the nurse to act within the law. The second is a minimum quality standard ('the rule of negligence'), that requires a nurse who takes on a role or task previously performed by a doctor, for example, to perform that role or task to the same standard as a doctor. It is essential that nurses who take on new roles are aware of the legal boundaries relating to the role, and that they have sufficient training and preparation to ensure that they can perform the role to the required standard.

Specific legal boundaries relating to CNO's 10 key roles are as follows:

1. 'Order diagnostic investigations such as pathology tests and X-rays'

Requesting tests on specimens such as blood or urine is not regulated specifically by the law.

Requesting radiological examinations (i.e. X-rays) is regulated by the Ionising Radiation (Medical Exposure) Regulations 2000. The IR(ME)R define the 'referrer' (that is, person requesting the X-ray) as 'a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with the employer's procedures to refer individuals for medical exposure to a practitioner' (that is, the person justifying the X-ray). The duties of the referrer are described as follows:

'The referrer shall supply the practitioner with sufficient medical data ... relevant to the medical exposure requested by the referrer to enable the practitioner to decide on whether there is sufficient net benefit as required by regulation 6(1)(a).'

(Regulation 6(1)(a) requires that exposures can only be carried out when justified by the practitioner. Strictly, the referrer is requesting a clinical opinion from the practitioner rather than a X-ray examination.)

Nurses may therefore be 'referrers' under these Regulations, provided they have the competence (conferred by training and experience) to provide the medical data required to enable the practitioner (usually a radiologist) to decide whether there is net benefit to the patient from the exposure. They would also need the agreement of their employer that this task can be part of their role. This entitlement to act as a referrer would also specify the

scope of referrals: that is, the types or range of conditions for which the nurse can be the referrer (e.g. for injuries to extremities only).

2. 'Prescribe medicines and treatments'

Prescribing is regulated by the Medicines Act 1968 and Regulations: The Prescription Only Medicines (Human Use) Amendment Order 2002; NHS (Charges for Drugs and Appliances) Amendment Regulations 2002; and The NHS (Pharmaceutical Services) and (General Medical Services) (No 2) Amendment Regulations 2002.

At present there are two forms of nurse prescribing: district nurse and health visitor prescribing (these nurses can prescribe from the Nurse Prescribers' Formulary for District Nurses and Health Visitors); and 'extended nurse prescribing', which is open to all 1st level nurses and midwives who successfully complete the specific programme of preparation. These nurses and midwives can prescribe from a much larger list, the Nurse Prescribers' Extended Formulary. Full details can be found on www.doh.gov.uk/nurseprescribing

It is planned to introduce 'supplementary prescribing' for nurses – prescribing following diagnosis by a doctor and agreement of an individual Clinical Management Plan – from the end of 2002, following responses to a public consultation which concluded on 9 July 2002. Full details of supplementary prescribing can be found on www.doh.gov.uk/supplementaryprescribing

3. 'Take the lead in the way local health services are organised and in the way that they are run'

While the formal constitution of an NHS Trust Board, and a PCT Board and Executive Committee, is governed by the legislation setting up these NHS bodies, this role refers to much wider opportunities for leadership and influence that occur at all levels in organisations, and there are no specific legal constraints on these roles.

Professional standards

All Registered Nurses and Registered Midwives are required to work within the Nursing and Midwifery Council's 'Code of Professional Conduct for Nurses, Midwives and Health Visitors'. The NMC is the statutory regulatory body for these professions, replacing the former United Kingdom Central Council for Nurses, Midwives and Health Visitors under the Nursing and Midwifery Order 2001. Its primary responsibility is to protect patients by setting and maintaining standards of entry to the profession and of professional conduct following registration, and holding the 'register' of qualified nurses and midwives.

The latest (2002) edition of the Code of Professional Conduct incorporates guidance on enlarging the scope of a nurse's practice, previously published separately as 'The Scope of Professional Practice'. This places a specific requirement on the nurse to *'acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent. If an aspect of practice is beyond your level*

of competence ... you must obtain help and supervision from a competent practitioner until you and your employer consider that you have acquired the requisite knowledge and skill'.

A nurse cannot therefore be required by an employer to take on a new role or task if they do not consider themselves to be competent to do so without breaching the Code of Professional Conduct and being open to a charge of professional misconduct.

The Code of Professional Conduct also makes clear that the nurse, midwife or health visitor is personally accountable for his/her actions, in addition to their accountability to their employer. Professional accountability cannot be delegated or suspended by the nurse or their employer.

Professional indemnity insurance

Almost all nurses and midwives have professional indemnity insurance through their membership of a professional organisation or trade union such as the Royal College of Nursing or the Royal College of Midwives. This covers the cost of legal representation and support, and third party damages, up to a pre-set limit.

Employer's liability

When a nurse is employed by an NHS organisation, that organisation has vicarious liability for the nurse's actions. This is in addition to the nurse's own professional accountability to the NMC. It is important that any extension to a nurse's role, or new role, is reflected in the job description for the post, so that it is clear that the employer is aware that the nurse is taking on the new role or task.

4.2 Examples from the evidence base

There are many examples of research into the value of developing nurses' and midwives' roles. Some of these are:

Elkan, R., Kendrick, D., Hewitt, M., et al. (2000) The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. *Health Technology Assessment*, Vol 4, 13.

Elliott, L., Crombie, I. K., Irvine, L., Cantrel, J. and Taylor, J. (2001) *The Effectiveness of Public Health Nursing: A review of systematic reviews*. Scottish Executive, The Stationery Office, Edinburgh.

Guest, D., Redfern, S., Wilson-Barnett, J. et al (2001) *A Preliminary Evaluation of the Establishment of Nurse, Midwife and Health Visitor Consultants: A report to the Department of Health*.

Kinley, H. et al (2001) Extended scope of nursing practice: a multicentre randomised controlled trial of appropriately trained nurses and pre-

registration house officers in pre-operative assessment in elective general surgery. *Health Technology Assessment*, Vol 5 No 20.

Kinnersley, P. et al (2000) Randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting 'same day' consultations in primary care. *British Medical Journal*, Vol 320, pp1043-8.

Luker, K. et al (1997) *Evaluation of Nurse Prescribing – Final Report* [Executive Summary].

Read, S. and ENRiP Team (1999) *Exploring New Roles in Practice: implications of the developments within the clinical team* [Executive Summary]. University of Sheffield.

Shum, C. et al (2002) Nurse management of patients with minor illnesses in general practice: multicentre, randomised, controlled trial. *British Medical Journal*, Vol 320, pp1038-43.

The Department of Health has commissioned further research, as part of its nursing quality research programme, into:

- the use of skill mix workforce planning tools
- stage 2 evaluation of the developing role of the nurse, midwife and health visitor consultant
- evaluation of the 'modern matron' role
- evaluation of 'Extended Formulary' nurse prescribing.

Full details of the Department's research programmes, including calls for proposals and final reports, can be found at www.doh.gov.uk/research

Nursing and other professional journals publish many descriptive accounts of the introduction of new roles in practice which may also be helpful.

Other resources that may be helpful include:

Ovretveit, J. (1998) *Evaluating Health Interventions*. Open University Press, Milton Keynes.

Patton, M. (1997) *Utilization Focused Evaluation*, (3rd edition). Sage, Thousand Oaks.

St. Leger, A., Schnieden, H. and Wadsworth-Bell, J. (1992) *Evaluating Health Services Effectiveness*. Open University Press, Milton Keynes.

4.3 Resources and websites

Department of Health

For policy documents and National Service Frameworks

<http://www.doh.gov.uk>

See in particular the pages: /cno /nurseprescribing
/supplementaryprescribing /research

National Electronic Library for Health

For access to databases of evidence and good practice

<http://www.nelh.nhs.uk>

NHS Centre for Reviews and Dissemination

<http://www.york.ac/inst/crd/em51.htm>

Nursing and Midwifery Council

The regulatory body for information on education, regulation and professional issues for nurses and midwives

www.nmc-uk.org.uk

Royal College of Nursing

Information on employment and professional issues for nurses

www.rcn.org.uk

Royal College of Midwives

Information on employment and professional issues for midwives

www.rcm.org.uk

Sample Patient Group Directions

For the supply of medicines by nurses and other registered professionals

www.groupprotocols.com

School Nurse and Health Visitor Innovation Projects at

<http://www.innovate.hda-online.org.uk>

WISDOM resource database on evidence based practice (UK)

<http://www.shef.ac.uk/uni/projetcs/wrp/seminar.html#EBP>

Our Healthier Nation in Practice Database

<http://www.ohn.gov.uk/database/database.htm>

Health Development Agency (HDA) website

<http://www.hda-online.org.uk/>

Health Technology Assessment website

For systematic reviews

<http://www.hta.nhsweb.nhs.uk/htapubs.htm>

Public Health Research, Education and Development Programme

<http://www.health.hamilton-went.on.ca/CSARB/ephpp/ephpp.htm>

4.4 Contact details for the case studies

1. Sheila Adam: Ordering diagnostic investigations

Contact: Name: Ms Sheila Adam
 Job Title: Consultant Nurse
 Address: ICU
 Middlesex Hospital
 Mortimer Street
 London
 W1N 8AA
 Telephone: 020 7380 9008
 Fax: 020 7636 3264
 Email: sheila.adam@uclh.org
Available: Algorithms, job description for outreach team

2. Helen Dunshea: Making and receiving referrals direct

Contact: Name: Ms Helen Dunshea
 Job Title: Parent Advisor
 Address: Parent Advisory Service
 Cheshire West PCT
 Moston Lodge
 Countess of Chester Health Park
 Liverpool Road
 Chester
 CH2 1UL
 Telephone: 01244 364091
Available: Job description, standards, audit report

3. Shelagh Cartmell: Making and receiving referrals direct

Contact: Name: Ms Shelagh Cartmell
 Job Title: Ward Manager
 Address: University Hospital of North Durham
 North Road
 Durham
 DH1 5TW
 Telephone: 0191 333 2364
 Email: shelagh.cartmell@ndhcnt.northy.nhs.uk
Available: Protocols, checklists

4. Pam Leonard: **Admitting and discharging patients**

Contact: Name: Ms Pam Leonard
 Job Title: Ward Manager and Unit Leader
 Address: Ward M4
 Wirral Hospital NHS Trust
 Clatterbridge Hospital
 Bebington
 Merseyside
 CH63 4JY

 Telephone: 0151 482 7642
 Fax: 0151 482 7642
 Email: www.wirralhealth.org.uk/wardM4

Available: Protocol, standard, audit tool

5. Sheila Cartmell: **Admitting and discharging patients**

Contact: Name: Ms Shelagh Cartmell
 Job Title: Ward Manager
 Address: University Hospital of North Durham
 North Road
 Durham
 DH1 5TW

 Telephone: 0191 333 2364
 Email: shelagh.cartmell@ndhcnt.northy.nhs.uk

Available:

6. Helen Watson: **Managing patient caseload**

Contact: Name: Dr Helen Watson
 Job Title: Public Health Consultant
 Address: Northumberland Care Trust
 Merley Croft
 Loansdean
 Morpeth
 Northumberland
 NE61 2DL

 Telephone: 01670 394407
 Fax: 01670 394501
 Email: helen.watson@email.nhumberld-ha.northy.nhs.uk

Available: Protocols, job descriptions

7. Valerie Goode: **Running clinics**

Contact: Name: Ms Valerie Goode
 Job Title: Nurse Clinician in Oncology
 Address: Christie NHS Trust
 Christie Hospital
 Wilmslow Road
 Withington
 Manchester
 M20 4BX

 Telephone: 0161 446 3395
 Fax: 0161 446 3461

Available: Treatment protocols, job description

8. Dorothy Miller: Prescribing medicines and treatments

Contact: Name: Ms Dorothy Miller
Job Title: Practice Nurse
Address: Garden Lane Medical Centre
19 Garden Lane
Chester
CH1 4EN
Telephone: 01244 346677
Fax: 01244 310094
Email: dorothy.miller@gp-n81081.nhs.uk
Available: Protocols

9. Angela Bates: Prescribing medicines and treatment

Contact: Name: Ms Angela Bates
Job Title: Nurse Clinician for Homeless and Vulnerable People
Address: Cheshire West PCT
Moston Lodge
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1UL
Telephone: 01244 364616 mobile: 07733 110443
Fax: 01244 364822
Email: angela.bates@cahc-tr.nhs.co.uk
Available: Patient Group Direction, hand held record, protocol, job description

10. Debbie Hughes: Carrying out resuscitation procedures

Contact: Name: Ms Debbie Hughes
Job Title: Clinical Nurse Specialist in Cardiology
Address: South Devon Health Care Trust
Torbay Hospital
Lawes Bridge
Torquay
TQ2 7AA
Telephone: 01803 655047 / 655057
Email: debbie.hughes@sdevonhc-tr.swest.nhs.uk
Available: Protocols, policies, training schedules

11. Roy Pryer: Carrying out resuscitation procedures

Contact: Name: Mr Roy Pryer
Job Title: Acting Senior Resuscitation Officer
Address: Resuscitation Training Department
Brighton and Sussex University Hospitals NHS Trust
The Royal Sussex County Hospital
Eastern Road
Brighton
BN2 5BE
Telephone: 01273 664524
Fax: 01273 664524
Email: roy.pryer@bsuh.nhs.uk
Available: Protocols, policies, job descriptions

12. Susan Osborne: Performing minor surgery

Contact: Name: Ms Susan Osborne
Job Title: Director of Nursing
Address: Nursing Directorate
St Mary's Hospital NHS Trust
Ground Floor, Clarence Wing
Praed Street
London
W2 1NY
Telephone: 020 7886 1482
Fax: 020 7886 1843
Email: susan.osborne@st-marys.nhs.uk
Available: Clinical guidelines, protocols, job descriptions

13. Andrew Jackson: Performing minor surgery and outpatient procedures

Contact: Name: Mr Andrew Jackson
Job Title: Consultant Nurse IV Therapy and Care
Address: Vascular Access Team
Rotherham General Hospitals NHS Trust
Level D
Moorgate Road
Rotherham
S60 2UD
Telephone: 01709 304745
Fax: 01707 307546
Email: Andrew.Jackson@rothgen.nhs.uk
Available: Protocols, policies, job descriptions

14. Ann Ballarini: Triage patients using latest IT

Contact: Name: Ms Ann Ballarini
Job Title: Director of Clinical Services
Address: Doncaster Central PCT
White Rose House
Ten Pound Walk
Doncaster
DN4 5DJ
Telephone: 01302 320111 ext 3209
Email: ann.ballarini@doncastercentralpct.nhs.uk
Available: Training course outline and materials, job description

15. David MacPhee: Triage patients using latest IT

Contact: Name: Mr David MacPhee
Job Title: Nurse Consultant
Address: Northumbria Healthcare NHS Trust
North Tyneside General Hospital
Rake Lane
North Shields
Tyne and Wear
NE29 8NH
Telephone: 0191 293 2753
Available: Job description, protocols

16. Sue Foyle: Taking a lead in organisation of local services

Contact: Name: Ms Sue Foyle
 Job Title: Consultant Midwife
 Address: Doncaster and Bassetlaw NHS Trust
 Bassetlaw Hospital
 Kilton
 Worksop
 Nottinghamshire
 S81 0BD
 Telephone: 01909 502218
Available: Policies, protocols

17. Rob Crouch: Taking a lead in the organisation of local services

Contact: Name: Dr Rob Crouch
 Job Title: Nurse Consultant and Senior Lecturer
 Address: Southampton University Hospital NHS Trust and
 University of Southampton
 Southampton General Hospital
 Tremona Road
 Shirley
 Southampton
 SO16 6YD
 Telephone: 023 8079 8839
 Fax: 023 8079 6297
 Email: robert.crouch@suht.swest.nhs.uk
Available: Policies, protocols, job descriptions

References

- 1 Department of Health (2000) *The NHS Plan: A plan for investment, A plan for reform*. Department of Health: London.
- 2 Department of Health (1999) *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and health care*. Department of Health: London.
- 3 Department of Health (2002) *Improvement, Expansion and Reform: The next 3 years priorities and planning framework 2003-2006* at www.doh.gov.uk/planning2003-2006/index.htm